HM PRISON SERVICE

Public Sector Prisons

East Sussex Downs and Weald NHS

Primary Care Trust

HM Prison Lewes

Healthcare Needs Assessment 2008

1. Introduction

Prisoners are not representative of the general population in terms of their health and health needs (Box 1). There a greater proportion of individuals with mental health problems, substance misuse and homelessness in prison populations in comparison to the general population.[1] Many prisoners have had little or no regular contact with health services before coming into prison, and prison populations reveal strong evidence of health inequalities and social exclusion.[2]

Box 1. Health characteristics of prisoners in England and Wales

- The majority of prisoners are young and male.
- Most prisoners are in custody for periods of weeks or months, rather than years.
- Sixty to seventy per cent of them were using drugs before imprisonment and over 70% suffer from at least two mental disorders.
- It is estimated that at least 80% of prisoners smoke.
- Sixty-six percent of all injecting drug misusers in the community have been in prison at some time, of whom half had been in prison before they started injecting.
- Male prisoners are much more sexually active in the community than the general population; all age groups having more lifetime sexual partners, and more partners in the year before entry to prison, than would be expected from the general population. They are also six times more likely to have been a young father.

In 1996 Her Majesty's Chief Inspector of Prisons, an independent authority, published a highly critical review entitled *Patient or Prisoner? A new strategy for healthcare in prisons*.[3] This publication drew to public and political attention the problems of the healthcare in prisons across England and Wales and illustrated that prisoner's health needs were not being properly assessed or met in comparison to those in the community.[4]

In an attempt to remove the variation in healthcare service provision within the prison service across the country the responsibility for commissioning, and in some cases providing, health was transferred from the Prison Service to the NHS between 2004 and 2006.[5] Primary Care Trusts, in partnership with their local prison, are now responsible for ensuring that prisoners can access the same standards of healthcare as those provided by the NHS in the community.[6]

The UK government has signalled its commitment to reducing health and social inequalities with respect to prisons by signing up to the World Health Organisation's Health in Prison Project, which aims to improve prison health through facilitating links between public health and the prison health systems at a national and international level. The combination of these factors has led to an increased emphasis on the opportunities that prison presents to address the health needs of less-advantaged groups, many of whom make little use of health services outside of prison.[7]

A set of voluntary prison health indicators have been designed by the Departments of Health and HM Prison service specifically to measure the quality of prison health services and to help achieve the objective of NHS-equivalent standards. The data is from these indicators is reported nationally, and is intended to support and inform existing local performance management processes (Box 2).

Box 2. Prison health performance indicators

Health needs assessment
A comprehensive Health Needs Assessment, or refresh, has been undertaken within the Prison, within the last 12 months. It includes all the following: information relating to the *frequency of chronic illnesses*, *outcomes of screening programme*, *prisoner demographic profile*, *health service activity in prison* and *referrals to NHS*. It also contains agreed *annual health priorities* which are published in the local prison health delivery plan and signed off by the prison governor and the chief executive of the local/ PCT.

Service user involvement The *views of service users, their carers (including prison staff) and others are sought and taken into account* in designing, planning, delivering and improving healthcare services. Formal procedures are in place to ensure involvement and such involvement is documented accordingly.

Comprehensive range of services
The complete range and capacity of services, which have been identified as necessary within the Health Needs Assessment and through service user involvement, are provided to the prisoner population.

In order to assess and meet prisoner's needs one of the central indicators is that a comprehensive Healthcare Needs Assessment (HCNA), or refresh, is undertaken annually. The aim of a HCNA is: to provide a structured assessment of the health needs of prisoners; to identify gaps in service planning; and to improve services.

Her Majesty's Prison Lewes is a Victorian-built male local Category B prison (Box 3). It holds both remanded and convicted adult prisoners, as well as young offenders on remand. It serves the courts of East and West Sussex and occupies a 14 acre site on the edge of Lewes town. Responsibility for providing and commissioning healthcare services within HMP Lewes transferred to East Sussex Downs and Weald Primary Care Trust (formerly Sussex Downs and Weald PCT) in 2005. Initial HCNA were undertaken in HMP Lewes in 2000 and 2004 prior to the transfer of health services.[8,9] This report provides an updated HCNA of HMP Lewes in light of the changes in healthcare provision and attempts to estimate the impact of the current expansion of the prison.

Box 3. HM Prison Categories

Category A
Prisoners who escape would be highly dangerous to the public or the police or the security of the state, no matter how unlikely that escape might be, and for whom the aim must be to make escape impossible.

Category B
Prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult.

Category C
Prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt.

Category D
Prisoners who can be reasonably trusted in open conditions

2. Demography

The prison population is highly mobile and varies over time. Three main data sources have been used for the demographic profile: HMP Lewes prisoner records 2004-07; a snapshot of the prison population taken in November 2007; and reducing re-offending needs assessment at HMP Lewes.[10] As a result the numbers presented may not match in each section. However, source information is provided as clarification.

The reducing re-offending needs assessment was based on an administered questionnaire survey of 96 prisoners at HMP Lewes which was completed between December 2007 and March 2008. The survey covered the seven pathways of the national *Reducing Re-offending Action Plan* which include: accommodation; education training and employment; mental and physical health; drugs and alcohol; finance benefit and debt; children and families of offenders; and attitudes, thinking and behaviour.[11]

The accommodation capacity of HMP Lewes is outlined in Table 1.

Table 1: Accommodation capacity and usage of residential wings at HMP Lewes

Unit Name	Baseline CNA	In use CNA	Operational Capacity	Type of usage
A Wing	133	133	134	These inmates are mainly on remand to Magistrate Courts or have been committed for trial at Crown Courts.
B Wing	16	16	29	A 29 bedded drug detoxification unit
C Wing	149	149	162	These inmates are either convicted and awaiting sentence **OR** Sentenced and awaiting allocation to a suitable prison **OR** Sentenced and awaiting transfer to other prisons to which they have been allocated. **OR** Sentenced to short-term imprisonment who will serve the total sentence at Lewes Prison.
D Wing [Healthcare Centre]	19	19	19	Dedicated primary care suite, 19 bed in-patient unit, dental surgery
F Wing	88	88	158	Mainly an older population serving longer sentences for offences such as sex offences. Often require increased medical input.
G Wing	22	22	25	Convicted inmates who are participating in an introduction programme.
K Wing	22	22	22	First night centre.
F1 – Care & Support Unit (CASU)	9	9	9	Vulnerable Prisoner Unit/Young Offenders
F1 – Segregation	0	0	0	Good Order Or Discipline (GOOD)/Constant Watch
Total established	**458**	**458**	**558**	
New Build				
L Wing	84			Mainly serving longer sentences for offences. Often require increased medical input.
M Wing	90			Mainly serving longer sentences for offences. Often require increased medical input.
Total new build	**174**		**176**	
Post April 2008 Total	**632**		**734**	

A new purpose-built residential block holding 174 prisoners opened in March 2008, which has seen the prison's expected certified normal accommodation (CNA) rise from 458 to 632, with an operational capacity of 734.

The Healthcare centre, D wing, was refurbished in 2007 and is comprised of:

- a dedicated primary care suite with three consulting rooms;
- a 19-bed in-patient unit for both acute mental health assessment of patients and the care of prisoners who are physically unwell: the unit also has facilities for disabled prisoners;
- a dental surgery; and

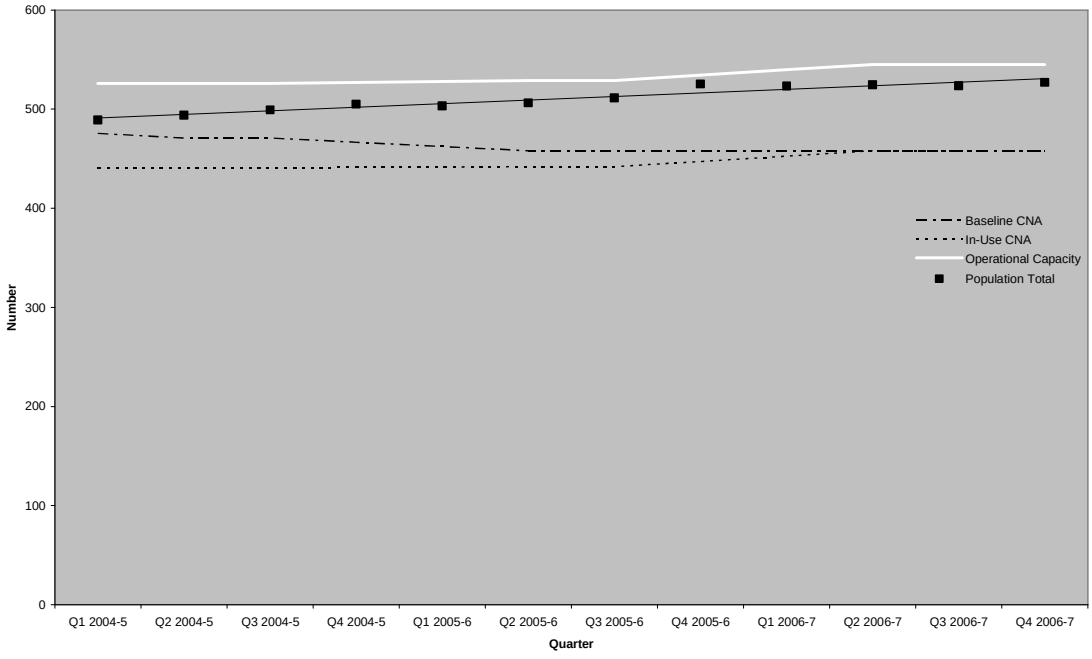
- a full time pharmacy, which is located in a neighbouring building.

Special 'safer custody' windows in the doors of cells without ligature points (to reduce suicide risk) have replaced Victorian barred windows. Five of the in-patient beds have special moulded furniture in the cells so patients identified as being at an acute risk of suicide can be placed in a safer environment with 24-hour constant supervision.

2.1 Prison Population

The mean average daily population (ADP) between April 2004 and March 2007 was 522 (95%CI 514-528). Figure 1 shows the 3 month average population over this time period. There has been a general upwards trend towards occupancy levels at operational capacity, with an average of 95.6% (95%CI 94.9-96.3) operational capacity filled.

Figure 1: Average monthly population by quarter 2004-2007



Source: HMP Lewes

The lowest monthly average population was in June 2004, with 482 prisoners, and the highest monthly average population was in July 2006 at 553.

The mean average number of new receptions the prison received per month was 216 (95%CI 201-231). This figure includes prisoners transferred into Lewes from other establishments. The turnover rate of the prison population was five times the ADP over the three years 2004-07. The mean number of prisoners discharged from HMP Lewes per month during this period was 44 (excluding the number transferred to other prisons).

2.1 Category of Prisoner

HM Prison Lewes is a closed Category B prison, a snapshot of prisoner security category from November 2007 revealed that 9.6% (46) of prisoners were young offenders, over two thirds (31) of whom were Category U (unsentenced male remands). Of the adult population 47.1% were Category C; 39.7% Category U; 9.6% Category B; 2.7% Not Categorised Sentenced; and 0.8% Category D.

Over the period 2004-07 approximately 26% of the total prison population were unsentenced at anyone time.

Table 2 outlines the main offences for which prisoners were admitted to HMP Lewes

Table 2: Number and proportion of prisoner's main offence

Main offence	Number	%	Cumulative %
Other violence against the person*	85	17.7	17.7
Robbery	47	9.8	27.5
Burglary	47	9.8	37.3
Theft	38	7.9	45.2
Other criminal offences	35	7.3	52.5
Conspiracy charges	29	6.0	58.5
Holding warrant	28	5.8	64.4
Sex offences	26	5.4	69.8
Drugs – possession	24	5.0	74.8
Drugs – supply	21	4.4	79.2
Murder	20	4.2	83.3
Breach offences	16	3.3	86.7
Drugs – importation	13	2.7	89.4
Driving offences	13	2.7	92.1
Fraud/forgery	8	1.7	93.8
Immigration act	8	1.7	95.4
Arson	7	1.5	96.9
Kidnap/abduction	6	1.3	98.1
Firearms offences	5	1.0	99.2
Blackmail	2	0.4	99.6
Recall	2	0.4	100.0

*Includes: less serious wounding; threat or conspiracy to murder; harassment; and assault without injury.
Note: this list includes prisoners of any status i.e. on trial, convicted and sentenced
Source: HMP Lewes: snapshot November 2007

According to data collected by the Learning and Skills department, the average length of prisoners' sentence during this period was 736 days, just over 2 years (Table 3). At the time of the snapshot those with sentences of four to ten years and those with sentences greater than 12 months but less than two years were the most common.

Table 3: Length of sentence

Description	Number	%
less than 6 months	44	15.7%
6 months less than 12 months	29	10.3%
12 months less than 2 years	48	17.1%
2 years less than 3 years	33	11.7%
3 years less than 4 years	32	11.4%
4 years less than 10 years	52	18.5%
10 years less than life	7	2.5%
life/custody life	36	12.8%

Source: Reducing re-offending needs assessment at HMP Lewes 2008

2.2 Age

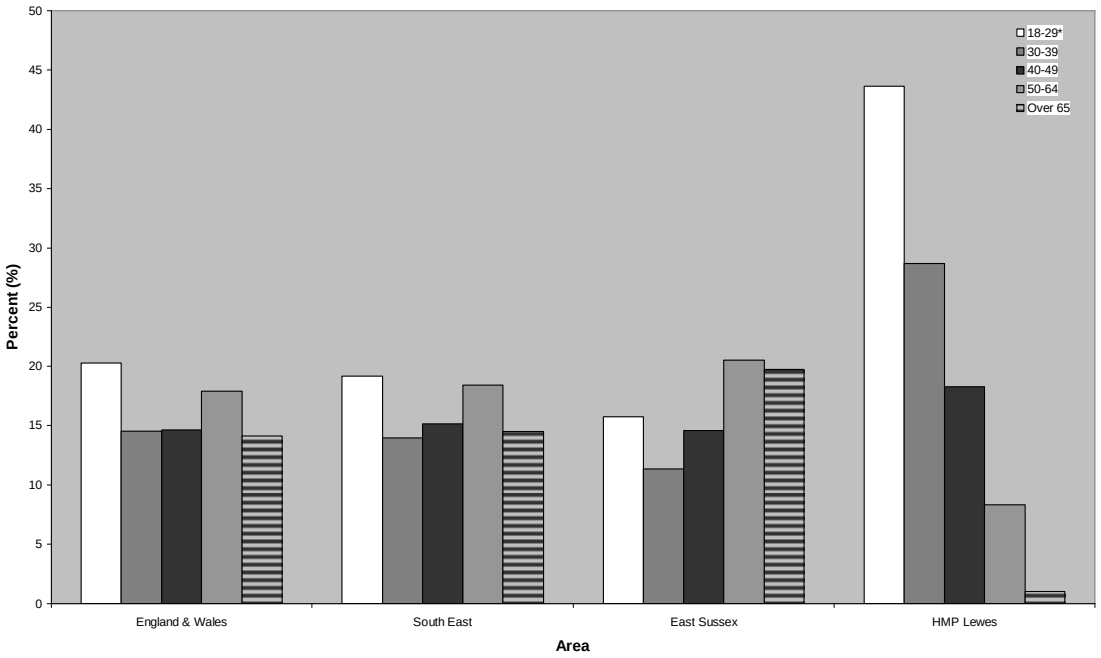
The age profile of the HMP Lewes (snapshot November 2007; Table 4) shows a high proportion of those aged 22-29 years (34.1%) and those aged 30-39 years (28.7%). When compared to the national, regional, and county profile (Figure 2) it can be clearly seen there is an over representation of the younger age-groups and under representation of the older age groups. This is typical of the UK prison population.

Table 4: Age profile of prisoners, snapshot November 2007

Age Range (years)	Number	%
18-21	46	9.6
22-29	164	34.1
30-39	138	28.7
40-49	88	18.3
50-65	40	8.3
Over 65	5	1

Source: HMP Lewes

Figure 2: Age profile of HMP Lewes, England & Wale, the South East and East Sussex



* Note: for EW, SE and ES estimates 15-29 years.
Source: ONS 2006 mid-year population estimates and HMP Lewes

2.3 Ethnicity

Ethnic monitoring data shows that between 2004 and 2007 an average of 84% of prisoners identified themselves as white. Table 5 compares the proportion of prisoners in each of the level one census ethnicity groupings compared to the 2005 ONS population estimates by ethnicity for the combined Brighton and Hove, East Sussex and West Sussex profile.

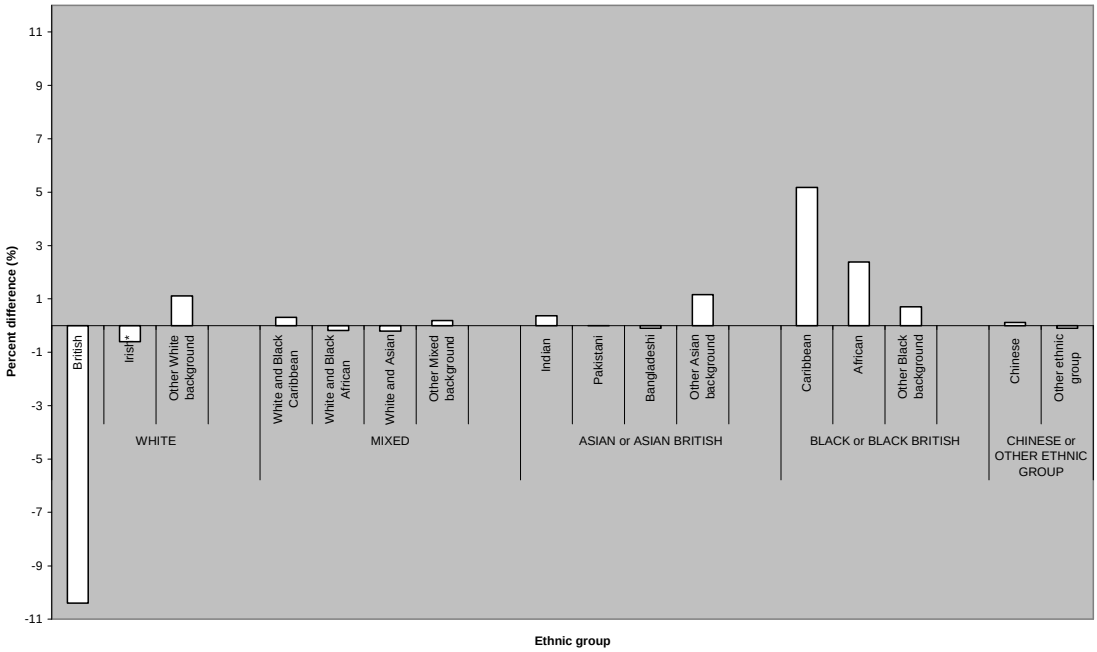
Table 5: Proportion of prison population identified in ONS ethnicity categories compared to Brighton and Hove, East Sussex and West Sussex.

Ethnic Group	Proportion	2005 ONS population estimates by ethnicity	Difference
White groups	84.7	95.6	-9.9
Mixed groups	1.4	1.1	+0.1
Asian or Asian British	3.5	1.3	+1.4
Black or Black British	9.2	1.0	+8.3
Chinese or Other Ethnic groups	1.0	1.0	+0.0
Not Stated	0.2		+0.2

Source: ONS 2005 mid-year population estimates by ethnicity and HMP Lewes

In comparison to the 2005 ONS population estimates there is a ten percent under representation of white prisoners. However, within this there is a greater under representation of white British (-10.4%) whilst those of other white backgrounds are over represented (+1.1%) (Figure 3). All black and minority ethnic groups are over represented in the prison population in comparison to the ethnic profile of East Sussex. This is most pronounced for the black and black British groups (8.3%).

Figure 3: Percent difference in ethnic profile of HMP Lewes population compared to Brighton and Hove, East Sussex and West Sussex.



Source: ONS 2005 mid-year population estimates by ethnicity and HMP Lewes

In November 2007 there were 88 foreign nationals at HMP Lewes: 19 (21%) from within the EU; 66 (75%) from non-EU countries; and 3 (3.4%) of unknown denomination.

2.4 Area of residence

According to data from the receptions and discharges database based on the Local Inmate Database System, prisoners entering HMP Lewes were received predominantly from East Sussex (34%). However, almost one quarter were registered as 'No Fixed Abode' (24%) and may also have come from the local area (Table 6).

Table 6: Area of residence

County	Number	Percent	Cumulative percent
East Sussex, including Brighton & Hove	1928	34.3	34.3
No Fixed Abode	1356	24.1	58.4
West Sussex	885	15.7	74.1
London	455	8.1	82.2
Kent	217	3.9	86.0
Surrey	185	3.3	89.3
Hampshire	109	1.9	91.3
Other	492	8.7	100.0

Source: HMP Lewes

Of the 34.3% from East Sussex, Brighton & Hove: 75% were from the three major centres in the area: Brighton & Hove (46%); Eastbourne (18%); and Hastings (12%) (Table 7).

Table 7: Town of residence for prisoners residing in East Sussex, Brighton and Hove and West Sussex

Town	Number	Percent	Cumulative percent
Brighton & Hove	872	45.7	45.7
Eastbourne	338	17.7	63.4
Hastings	230	12.1	75.5
Worthing	154	8.1	83.5
Crawley	146	7.7	91.2
Littlehampton	65	3.4	94.6
Chichester	59	3.1	97.7
Lewes	32	1.7	99.4
East Grinstead	12	0.6	100.0

Source: HMP Lewes

In the short term it is expected that the proportion of intake from out of area (i.e. outside the Surrey and Sussex courts) will increase. However, it is likely that as the population stabilises the proportion of out-of-area intake will drop back to historical levels.

3. Prevalence and Incidence

In both 2000 and 2004 HCNA inmate medical record audits were carried out to attempt to determine the prevalence of disease. In the absence of electronic records and the concerns raised in prior HCNA about the accuracy of hand-trawling records this exercise was not repeated for the current HCNA. The electronic records system SystemOne has been introduced to HMP Lewes. However, although being used for chronic disease management it is not currently being used for all prison records. There is also a large backlog of historic records which will require manual entering before the system is fully operational as a source of audit information. Pharmacy, substance misuse and sexual health screening are all held separately from the main inmate medical records system.

Due to the small size and the high turnover rate of prison populations it has been suggested that the measures of incidence and prevalence are not very meaningful in the prison setting.[12] However, as an indication of possible changes in workload for healthcare in light of the prison expansion synthetic estimates based on national prevalence rates have been calculated. Additionally, where possible, comparisons have been made to results from earlier HCNA at HMP Lewes.

3.1 Population assumptions

Because of the current expansion programme at HMP Lewes, a number of different assumptions have been used to make synthetic estimates of the expected numbers of prisoners with specific conditions; these are outlined in Table 7.

Table 8: Population assumptions used in synthetic estimates

Assumption	Total population	Assuming all new prisoners are sentenced		Assuming 74% of the total population has been sentenced*	
		Remand population	Sentenced population	Remand population	Sentenced population
1. Only Certified Normal Capacity filled	632	134	498	164	468
2. 95.6% Operational Capacity filled: this has been the average proportion of the OPCAP which was filled between April 2004 and March 2007.	705	134	571	183	522
3. 100% Operational Capacity filled	734	134	600	191	543

* Note: the average proportion of unsentenced prisoners between April 2004 and March 2007 was 26%
Note: numbers have been rounded

Where possible the different assumptions have been tested and compared to the numbers expected prior to the expansion and age-specific prevalence rates used to estimate numbers.

3.2 Physical health

A number of surveys indicate that the physical health of prisoners is worse than that of people of equivalent age in the general population.[13] Prisoners have a higher prevalence of chronic diseases compared to the general population.[14] There are three broad categories of reasons for this: Firstly, they are drawn predominately from a deprived population outside prison and so all the diseases that show an increased prevalence in deprived groups are also present more commonly in prison populations; secondly, there are disorders which are associated with incarceration including, for instance, mental health problems and learning disabilities; and lastly, there are a number of diseases and disorders that are the direct or indirect result of activities leading to incarceration, such as hepatitis from illegal substance misuse. [15]

Table 9 gives estimates for expected numbers of prisoners in the HMP Lewes population with specific conditions, including: epilepsy; asthma; ischaemic heart disease and other

cardiovascular disease risk factors; infectious disease; and sensory and physical disabilities.

Table 9: Estimated numbers of HMP Lewes prisoners with Physical conditions and health problems using population assumptions.

Condition		National prevalence (%)	Expected number in HMP Lewes population				Proportion of records reviewed in previous HCNA with diagnosis (%)	
			Prior to expansion (n=522)	Expansion CNC (n=632)	95.6% OPCAP (n=705)	100% OPCAP (n=734)	2000†	2004†
Epilepsy								
		0.83	4	5	6	6	0.8	5.0
Asthma								
	Wheezing in the past year	19	99	120	130	139		
	Diagnosed asthma	14	73	88	96	103	7.5	6.0
	Treated asthma	5	26	32	34	37		
Diabetes								
	Insulin dependent	0.5	3	3	3	4		
	Non-insulin dependent	0.3	2	2	2	2	0.8	2.0
IHD and cardiovascular risk factors								
	IHD		30	37	40	43	5.8	NA
	>10% 5 year risk of IHD (white)		40	54	58	62		
	>10% 5 year risk of IHD (black)		6	8	9	9		
Infectious disease								
	Hepatitis B	8	42	51	55	59	1.7	NA
	Hepatitis C	9	47	57	62	66	4.2	3.0
	HIV	0.3	2	2	2	2		
	TB							
Special senses and disability								
	Disability (mobility, hearing & visual)**	0.6	3	4	4	4		
	Speech and language problems***	11	57	70	75	81		

** Likely to be more prevalent in older inmates
*** Based on male younger offenders
† Proportions based on audit of 120 inmate medical records

Source: Adapted from Marshall et al 2001
Note: numbers have been rounded

The results from the 2004 HCNA for asthma and infectious disease suggest there is under diagnosis of these conditions with the prison population. This pattern is reversed for epilepsy and diabetes both of which were detected more commonly in the 2004 audit than national evidence suggests would be expected. These discrepancies may be due to the sampling technique in the audits under or over-detecting the presence of some conditions. However, in the absence of easily accessible and complete records it is difficult to make conclusions about the rate of under or over diagnosis of physical health conditions within the HMP Lewes population.

From Table 9 it can be seen that the increased population associated with the new build will have a significant impact on the number of patients with conditions of high overall prevalence. The age-profile of the prison population will also influence the projected expected numbers. If the average age of the population increases the numbers of prisoners with conditions such as ischaemic heart disease and non-insulin dependent diabetes will increase; if the prison population remains young the numbers of prisoners with asthma, epilepsy and non-insulin dependent diabetes are likely to increase further.

Although the expected numbers of prisoners with physical disability is not predicated to increase significantly with the new population size there may be increasing numbers of those with disability associated with chronic disease. This may be of increasing importance if the average age of the population increases. The number of prisoners with speech and language problems is estimated to increase by up to 42% with the expansion in prison population, although these estimates may not be representative of the HMP Lewes population as prevalence values are based on young offender populations.

3.2.1 Sexual health

Most of the focus of research into the prevalence of STIs within the prison environment in the UK has focused on Human Immunodeficiency Virus (HIV) and other blood borne viruses (BBV), in particular hepatitis B and hepatitis C.[16,17] Direct evidence on the prevalence of other STIs has been limited and often where estimates have been made they have been indirectly extrapolated from the general population.[18] However, due to increased risk, prison populations are likely to have higher infection rates than the general population.[19] In studies self-reported rates of lifetime infection have been recorded at over twenty percent, which is much higher than the twelve percent reported by the British National Lifestyle Survey general population survey.[20,21]

BBV are of particular interest in the prison populations as in world wide prevalence rates for these diseases are higher within prisons than in the general community.[22] In an unlinked questionnaire and antibody testing study of almost 4000 prisoners in the UK 0.14% tested positive for anti-HIV; 8% positive for anti- HCV and 7% for anti-HBV. [23] It was prisoners with known risks: men who have had sex with men within prison; and injecting drug users who were the most likely to have antibodies to blood borne infections.

Prisons are recognised globally as high-risk environments for BBV transmission.[24,25] Certain populations that are highly vulnerable to HIV infection have an elevated probability of imprisonment because they use illicit drugs and engage in sex work. [26] However, high risk activities such as sharing injecting equipment and unsafe sex also increase the risk of onwards transmission within the prison environment.[27]

A review of all inmates screened for hepatitis C was carried out between October 2004 and October 2007 at HMP Lewes. During this period there were 135 prisoners screened, of whom 21% (29) were found to be positive, of whom 96% (28) were intravenous drug users; 71% of these had injected in the 6 months prior to screening.[28]

3.2.2 Dental health

The consistent trend found in studies of dental health amongst prisoners is that in comparison to the general population their oral status is poor and that this trend continues in comparison with non-institutionalised individuals of similar socio-economic background. [29] Inmates show more decayed, more missing and similar or slightly higher mean DMFT than the non-institutionalised population. Considerable numbers of inmates are presenting with oral symptoms on initial examination, imposing a significant burden on the prison dental services.[30] Tables 10 and 11 provide estimated numbers of prisoners falling into the various categories of dental health based on population prevalence in adults of social class IV and V.

A prevalence study of caries in prisoners in the North West of England found that Prisoners enter prison with twice as many decayed teeth (mean 4.2) than found in the general population in the North West of England (mean 1.9). Prisoners also have fewer restored teeth. There was little difference in the mean DMFT of those in prison for more or less than two years. [31] If we assume the same ratio in the south east, where the mean DMFT is 1.3, the expected the mean DMFT for prisoners entering HMP Lewes is 2.9.[32]

Table 10: Estimated number of prisoners at HMP Lewes falling into the categories of dental health

Age band	Prior to expansion			Assuming new population equal to CNC (n=632)			Assuming new population equal to 95.6% OPCAP (n=705)			Assuming new population equal to 100% OPCAP (n=734)		
	>=21 standing teeth	>=18 sound teeth	>=12 filled teeth	>=21 standing teeth	>=18 sound teeth	>=12 filled teeth	>=21 standing teeth	>=18 sound teeth	>=12 filled teeth	>=21 standing teeth	>=18 sound teeth	>=12 filled teeth
16-24	114	104	0	138	126	0	150	136	0	161	146	0
25-34	197	125	20	239	151	24	266	168	27	277	175	28
35-44	97	34	20	118	41	24	131	46	27	137	48	28
45-54	38	12	14	46	15	16	51	17	18	53	17	19
55-64	7	1	2	9	1	2	10	2	2	10	2	3

Adapted from: Kelly et al 2000[33]
Note: numbers have been rounded

Table 11: Estimated numbers of decayed or unsound teeth among dentate HMP Lewes prisoners

Numbers of decayed or unsound teeth	Prevalence in social classes IV and V	Prior to expansion	Assuming new population equal to CNC (n=632)	Assuming new population equal to 95.6% OPCAP (n=705)	Assuming new population equal to 100% OPCAP (n=734)
0	47	245	297	331	345
1-5	48	56	68	74	79
>5	49	99	119	133	139
Mean DMFT	1.5				

Adapted from: Kelly et al 2000[34]
Note: numbers have been rounded

As with physical health, the age profile of the new population will influence the numbers of prisoners with unsound teeth requiring dental services. National data suggest that there has been a trend towards increasing numbers of sound teeth in younger age groups, but that there has been no corresponding increase in older age-groups.[35]

These trends have been seen across all social classes, therefore it would be expected that younger prisoners entering HMP Lewes will have better oral health than historically. However, the level of need in older prisoners is likely to remain similar with absolute numbers of prisoners with poor dental health indicators increasing.

3.3 Mental health

Individuals with mental disorders are significantly over-represented in the prison population.[36] The ONS psychiatric morbidity survey of 1997 found that in their sample 59% of remand and 40% of sentenced prisoners had a neurotic disorder.[37] An estimated rate three to five times that of the general adult population.[38] Remand prisoners are particularly associated with high levels of neurotic illnesses such as depression and anxiety. It is considered that the dislocation experienced when coming into prison, plus possible drug withdrawal combine to give this high level of emotional morbidity amongst remand prisoners.[39]

Functional psychoses such as schizophrenia, other delusional disorders, mania and severe depression have been found to be up to ten times more common in prisoners than in the general population.[40,41] In the ONS survey seven percent of sentenced men and ten percent of men on remand were assessed as having a psychotic illness within the past year.

Personality Disorders are long-standing and maladaptive patterns of perceiving and responding to other people and to stressful circumstances. Antisocial Personality Disorder (ASPD) is characterised by a gross disparity between behaviour and the prevailing social norms and a pervasive pattern of disregard for, and violation of, the rights of others. The prevalence of personality disorders and ASPD in particular, is high in the prison population. In England and Wales 78% of male remand prisoners and 64% of male sentenced prisoners have personality disorders, with the prevalence of ASPD being 63% among male remand prisoners (just over half of whom have ASPD plus another personality disorder) and 49% among sentenced male prisoners (two fifths of whom have ASPD plus another personality disorder).[42]

It is generally considered that the prevalence rates for offenders with intellectual disability may be higher than those in the general population. This is especially true for sexual offences and arson.[43]

Just under a quarter of male prisoners surveyed in the ONS study reported a suicide attempt at some time in their life. Self-harm during the current prison term, without the intention of suicide, was reported by approximately 6 per cent of male prisoners. The rates reported by remand and sentenced prisoners were similar. However, two thirds of remand prisoners had been in prison for less than three months compared with only about a quarter of the sentenced prisoners.[44]

Tables 12a, 12b and 12c present the estimated numbers of prisoners with mental health disorders at HMP Lewes using the various population estimates. Because of the difference in the prevalence of different conditions between remand and sentenced prisoners, particularly neurotic disorders two assumptions have been tested for each potential change in population: i) all new prisoners are sentenced; and ii) the proportion of remand prisoners remains the same as pre-expansion at 26%.

Table 12a: Estimated numbers of HMP Lewes prisoners with mental health conditions assuming that prison population is equivalent to the certified normal capacity (n=632).

Condition	Prevalence (%)		Prior to expansion (n=522)			Post expansion – assuming all new prisoners are sentenced (n=632)			Post expansion – assuming proportion of remand prisoners remains at 26% of total population (n=632)			Proportion of records reviewed with diagnosis (%)†	
	Prisoners under remand	Sentenced prisoners	Prisoners under remand (n= 134)	Sentenced prisoners (n=388)	Total estimated number	Prisoners under remand (n=134)	Sentenced prisoners (n=498)	Total estimated number	Prisoners under remand (n=164)	Sentenced prisoners (n=468)	Total estimated number	2000	2004
Personality disorders													
	78	64	105	248	353	105	319	423	128	299	427		
Functional psychoses													
in the past year	10	7	13	27	41	13	35	48	16	33	49		
Common neurotic disorders													
Sleep disorders	67	54	90	210	299	90	269	359	110	253	363		
Somatic symptoms	24	16	32	62	94	32	80	112	39	75	114		
Worry about physical health	11	16	15	62	77	15	80	94	18	75	93		
Neurotic disorders (in the past week)													
Post-traumatic stress disorder	5	3	7	12	18	7	15	22	8	14	22		
Mixed anxiety & depression	26	19	35	74	109	35	95	129	43	89	132		
Generalised anxiety disorder	11	8	15	31	46	15	40	55	18	37	55	21	12
Depressive episode	17	8	23	31	54	23	40	63	28	37	65	34	17
Phobias	10	6	13	23	37	13	30	43	16	28	44		
Obsessive-compulsive disorder	10	7	13	27	41	13	35	48	16	33	49		
Panic disorder	6	3	8	12	20	8	15	23	10	14	24		
Any neurotic disorder	59	40	79	155	234	79	199	278	97	187	284		
Self-harm and suicide													
Suicide attempts (past week)	2	0	3	0	3	3	0	3	3	0	3		
Suicide thoughts (past week)	12	4	16	16	32	16	20	36	20	19	38	**25	**5
Non-suicidal self-harm	5	7	7	27	34	7	35	42	8	33	41	35	6

† Proportions based on audit of 120 inmate medical records
** refers to any suicide ideation
Source: adapted from Marshall et al 2001
Note: numbers have been rounded

Table 12b: Estimated numbers of HMP Lewes prisoners with mental health conditions assuming that prison population is equivalent to 96% of the operational capacity (n=705).

Condition	Prevalence (%)		Prior to expansion (n=522)			Post expansion – assuming all new prisoners are sentenced (n=705)			Post expansion – assuming proportion of remand prisoners remains at 26% of total population (n=705)			Proportion of records reviewed with diagnosis (%)†	
	Prisoners under remand	Sentenced prisoners	Prisoners under remand (n= 134)	Sentenced prisoners (n=388)	Total estimated number	Prisoners under remand (n=134)	Sentenced prisoners (n=571)	Total estimated number	Prisoners under remand (n=183)	Sentenced prisoners (n=522)	Total estimated number	2000	2004
Personality disorders													
	78	64	105	248	353	105	365	470	143	334	477		
Functional psychoses													
in the past year	10	7	13	27	41	13	40	53	18	37	55		
Common neurotic disorders													
Sleep disorders	67	54	90	210	299	90	308	398	123	282	405		
Somatic symptoms	24	16	32	62	94	32	91	124	44	83	127		
Worry about physical health	11	16	15	62	77	15	91	106	20	83	104		
Neurotic disorders (in the past week)													
Post-traumatic stress disorder	5	3	7	12	18	7	17	24	9	16	25		
Mixed anxiety & depression	26	19	35	74	109	35	108	143	48	99	147		
Generalised anxiety disorder	11	8	15	31	46	15	46	60	20	42	62	21	12
Depressive episode	17	8	23	31	54	23	46	68	31	42	73	34	17
Phobias	10	6	13	23	37	13	34	48	18	31	50		
Obsessive-compulsive disorder	10	7	13	27	41	13	40	53	18	37	55		
Panic disorder	6	3	8	12	20	8	17	25	11	16	27		
Any neurotic disorder	59	40	79	155	234	79	228	307	108	209	317		
Self-harm and suicide													
Suicide attempts (past week)	2	0	3	0	3	3	0	3	4	0	4		
Suicide thoughts (past week)	12	4	16	16	32	16	23	39	22	21	43	**25	**5
Non-suicidal self-harm	5	7	7	27	34	7	40	47	9	37	46	35	6

† Proportions based on audit of 120 inmate medical records
** refers to any suicide ideation
Source: adapted from Marshall et al 2001
Note: numbers have been rounded

Table 12c: Estimated numbers of HMP Lewes prisoners with mental health conditions assuming that prison population is equivalent 100% operational capacity (n=734).

Condition	Prevalence (%)		Prior to expansion (n=522)			Post expansion – assuming all new prisoners are sentenced (n=734)			Post expansion – assuming proportion of remand prisoners remains at 26% of total population (n=734)			Proportion of records reviewed with diagnosis (%)†	
	Prisoners under remand	Sentenced prisoners	Prisoners under remand (n= 134)	Sentenced prisoners (n=388)	Total estimated number	Prisoners under remand (n=134)	Sentenced prisoners (n=600)	Total estimated number	Prisoners under remand (n=191)	Sentenced prisoners (n=543)	Total estimated number	2000	2004
Personality disorders													
	78	64	105	248	353	105	384	489	149	348	427		
Functional psychoses													
in the past year	10	7	13	27	41	13	42	55	19	38	49		
Common neurotic disorders													
Sleep disorders	67	54	90	210	299	90	324	414	128	293	363		
Somatic symptoms	24	16	32	62	94	32	96	128	46	87	114		
Worry about physical health	11	16	15	62	77	15	96	111	21	87	93		
Neurotic disorders (in the past week)													
Post-traumatic stress disorder	5	3	7	12	18	7	18	25	10	16	22		
Mixed anxiety & depression	26	19	35	74	109	35	114	149	50	103	132		
Generalised anxiety disorder	11	8	15	31	46	15	48	63	21	43	55	21	12
Depressive episode	17	8	23	31	54	23	48	71	32	43	65	34	17
Phobias	10	6	13	23	37	13	36	49	19	33	44		
Obsessive-compulsive disorder	10	7	13	27	41	13	42	55	19	38	49		
Panic disorder	6	3	8	12	20	8	18	26	11	16	24		
Any neurotic disorder	59	40	79	155	234	79	240	319	113	217	284		
Self-harm and suicide													
Suicide attempts (past week)	2	0	3	0	3	3	0	3	4	0	3		
Suicide thoughts (past week)	12	4	16	16	32	16	24	40	23	22	38	**25	**5
Non-suicidal self-harm	5	7	7	27	34	7	42	49	10	38	41	35	6

† Proportions based on audit of 120 inmate medical records
** refers to any suicide ideation
Source: adapted from Marshall et al 2001
Note: numbers have been rounded

In terms of the estimated numbers of prisoners with mental health conditions, the proportion of prisoners on remand in HMP Lewes is of increasing importance as the population size moves towards the new operational capacity. This is of particular importance for neurotic disorders and personality disorders, but will also have an effect on the estimated numbers with suicide ideation. The expected numbers of prisoners with functional psychoses is not predicted to increase dramatically. However, the predicted increase of 12 prisoners in the population assumption, 100% operational capacity with 26% remand prisoners, would increase the demand for mental health services within the prison, such as psychiatry input and inpatients facilities.

The proportions of prisoners identified as having anxiety, depression or non-suicidal self harm in the 2004 HCNA were similar to national prevalence levels.

3.4 Substance misuse

The prevalence of substance misuse and problematic drinking in prisoners of England and Wales is high, with implications not only for the health of prisoners, but also for substance-related crime. For most illicit drug users, the biggest criminological concern is acquisitive offending to fund the habit, whereas with alcohol it is violence and disorder.[45]

Over 85% of respondents to the ONS survey reported smoking, hazardous drinking or drug dependence in the year before coming to prison. In addition, 73% of male remand and 68% of male sentenced prisoners reported using two or more of these substances.

A large proportion (58% of remand and 63% of sentenced male prisoners) reported hazardous drinking (AUDIT score of 8+) in the year before coming to prison, including 30% with AUDIT scores which indicate severe alcohol problems (16 or above). Alcohol use and misuse is closely related to offending and re-offending behaviour:

- One third of people are intoxicated when they are arrested;
- 63% of men serving prison sentences had been hazardous or harmful drinkers in the year prior to incarceration; and
- People who are dependent on alcohol are more likely to be homeless on release from prison than those who are not.[46]

Survey respondents reported starting to use drugs at a young age, more than half starting to use one of the six drugs (cannabis, heroin, non-prescribed methadone, amphetamines, crack and cocaine powder) considered in detail in the survey before the age of 16. Approximately one in 10 men who were dependent on drugs in the year before prison reported receiving methadone treatment in the month before coming to prison.

The survey also found high rates of co-occurrence of mental disorder and alcohol or substance misuse. Over three quarters of those prisoners in all sample groups who were drug dependent before prison were assessed as having two or more other mental disorders.

Tables 13a, 13b and 13c provide synthetic estimates of numbers of prisoners with alcohol and substance misuse issues.

Table 13a: Estimated numbers of prisoners with substance misuse or alcohol dependence prior to entering HMP Lewes assuming population is equivalent to the certified normal capacity (n=632)

Condition	Prevalence (%)		Prior to expansion (n=522)			Post expansion – assuming all new prisoners are sentenced (n=632)			Post expansion – assuming proportion of remand prisoners remains at 26% of total population (n=632)		
	Prisoners under remand	Sentenced prisoners	Prisoners under remand (n= 134)	Sentenced prisoners (n=388)	Total estimated number	Prisoners under remand (n=134)	Sentenced prisoners (n=498)	Total estimated number	Prisoners under remand (n=164)	Sentenced prisoners (n=468)	Total estimated number
Alcohol use (year prior to prison)											
AUDIT score >32 (severe problem)	7	4	9	16	25	9	20	29	12	19	30
AUDIT score>8 (hazardous drinking)	58	63	78	244	322	78	314	391	95	295	390
Drug dependence (year prior to prison)											
Cannabis only	9	8	12	31	43	12	40	52	15	37	52
Stimulant only	17	16	23	62	85	23	80	102	28	75	103
Opiates and stimulants	15	10	20	39	59	20	50	70	25	47	71
Opiates only	11	8	15	31	46	15	40	55	18	37	55

Source: adapted from Petri A. and S. Copley 2007
Note: numbers have been rounded

Table 13b: Estimated numbers of prisoners with substance misuse or alcohol dependence prior to entering HMP Lewes assuming population is equivalent to 96% operational capacity (n=705)

Condition	Prevalence (%)		Prior to expansion (n=522)			Post expansion – assuming all new prisoners are sentenced (n=705)			Post expansion – assuming proportion of remand prisoners remains at 26% of total population (n=705)		
	Prisoners under remand	Sentenced prisoners	Prisoners under remand (n= 134)	Sentenced prisoners (n=388)	Total estimated number	Prisoners under remand (n=134)	Sentenced prisoners (n=571)	Total estimated number	Prisoners under remand (n=183)	Sentenced prisoners (n=522)	Total estimated number
Alcohol use (year prior to prison)											
AUDIT score >32 (severe problem)	7	4	9	16	25	9	23	32	13	21	34
AUDIT score>8 (hazardous drinking)	58	63	78	244	322	78	360	437	106	329	435
Drug dependence (year prior to prison)											
Cannabis only	9	8	12	31	43	12	46	58	16	42	58
Stimulant only	17	16	23	62	85	23	91	114	31	83	115
Opiates and stimulants	15	10	20	39	59	20	57	77	27	52	80
Opiates only	11	8	15	31	46	15	46	60	20	42	62

Source: adapted from Petri A. and S. Copley 2007
Note: numbers have been rounded

Table 13c: Estimated numbers of prisoners with substance misuse or alcohol dependence prior to entering HMP Lewes assuming population is equivalent to 100% operational capacity (n=734)

Condition	Prevalence (%)		Prior to expansion (n=522)			Post expansion – assuming all new prisoners are sentenced (n=705)			Post expansion – assuming proportion of remand prisoners remains at 26% of total population (n=705)		
	Prisoners under remand	Sentenced prisoners	Prisoners under remand (n= 134)	Sentenced prisoners (n=388)	Total estimated number	Prisoners under remand (n=134)	Sentenced prisoners (n=600)	Total estimated number	Prisoners under remand (n=191)	Sentenced prisoners (n=543)	Total estimated number
Alcohol use (year prior to prison)											
AUDIT score >32 (severe problem)	7	4	9	16	25	9	24	33	13	22	35
AUDIT score>8 (hazardous drinking)	58	63	78	244	322	78	378	456	111	342	453
Drug dependence (year prior to prison)											
Cannabis only	9	8	12	31	43	12	48	60	17	43	61
Stimulant only	17	16	23	62	85	23	96	119	32	87	119
Opiates and stimulants	15	10	20	39	59	20	60	80	29	54	83
Opiates only	11	8	15	31	46	15	48	63	21	43	64

Source: adapted from Petri A. and S. Copley 2007
Note: numbers have been rounded

Historically HMP Lewes has had more inmates test positive for drugs than any other prison in the country due to the population it serves. Both Brighton & Hove City and Hastings have large numbers of 'problematic drug users' including large numbers of injecting drug users. In 2001 it was estimated that there could be as many as 1800 problem drug users in Brighton and Hove raising money from acquisitive crime.[47]As such, the national estimates for opiate use amongst prisoners may in fact under estimate predicted numbers at HMP Lewes.

The 2004 HCNA of HMP Lewes found that 64% of the 120 inmate medical records reviewed noted alcohol use levels of 5-15 units per day. 'Hazardous' levels of drinking are classified as greater than four units of alcohol per day for men.[48]

4. Services activity

The responsibility for the commissioning of healthcare services within HMP Lewes was transferred to East Sussex Downs and Weald PCT (formally Sussex Downs and Weald PCT) in 2005. The model of healthcare delivery in prisons follows that of the community with primary care acting as a 'gatekeeper' to other services. Figure 4 illustrates the healthcare process for HMP Lewes.

All activity data predates the 2008 expansion of HMP Lewes and covers the period April 2006 to August 2007, although not all data was available for the entire period. In some sections supplementary information has been provided for different time periods.

4.1 Physical health

4.1.1 Health screening on arrival

Healthcare Standard One in Healthcare Standards for Prisons in England and Wales requires all prisoners to undergo health screening on arrival ay prison.

At HMP Lewes all new admissions are undergo an initial health-screen by nursing staff, followed by a secondary screen in the First Night Centre (K-wing) and are seen by a GP if urgently necessary or the following day in K-wing where required by the nurse, or requested by the inmate. All new admissions are assessed for: initial risk of self harm; potential admission to detoxification programme; fitness to work or attend gym; and whether they can be assigned to an ordinary location or require a ground floor location.

4.1.2 Primary care

Primary care services are provided through the outpatient department (ODP) seven days a week between 0700 and 2100 hours. Prisoners can request appointments in the morning when nurses visit the wing, via general application. The OPD is responsible for the provision of: GP and nurse-led clinics; drug administration to wings; dentistry; podiatry; optometry; sexual health; chronic disease management; reception and secondary screening; daily segregation visits; emergency calls to wings and other areas of the prison; smoking cessation; immunisations; monitoring prisoners out on bed-watch; suturing; venepuncture etc.

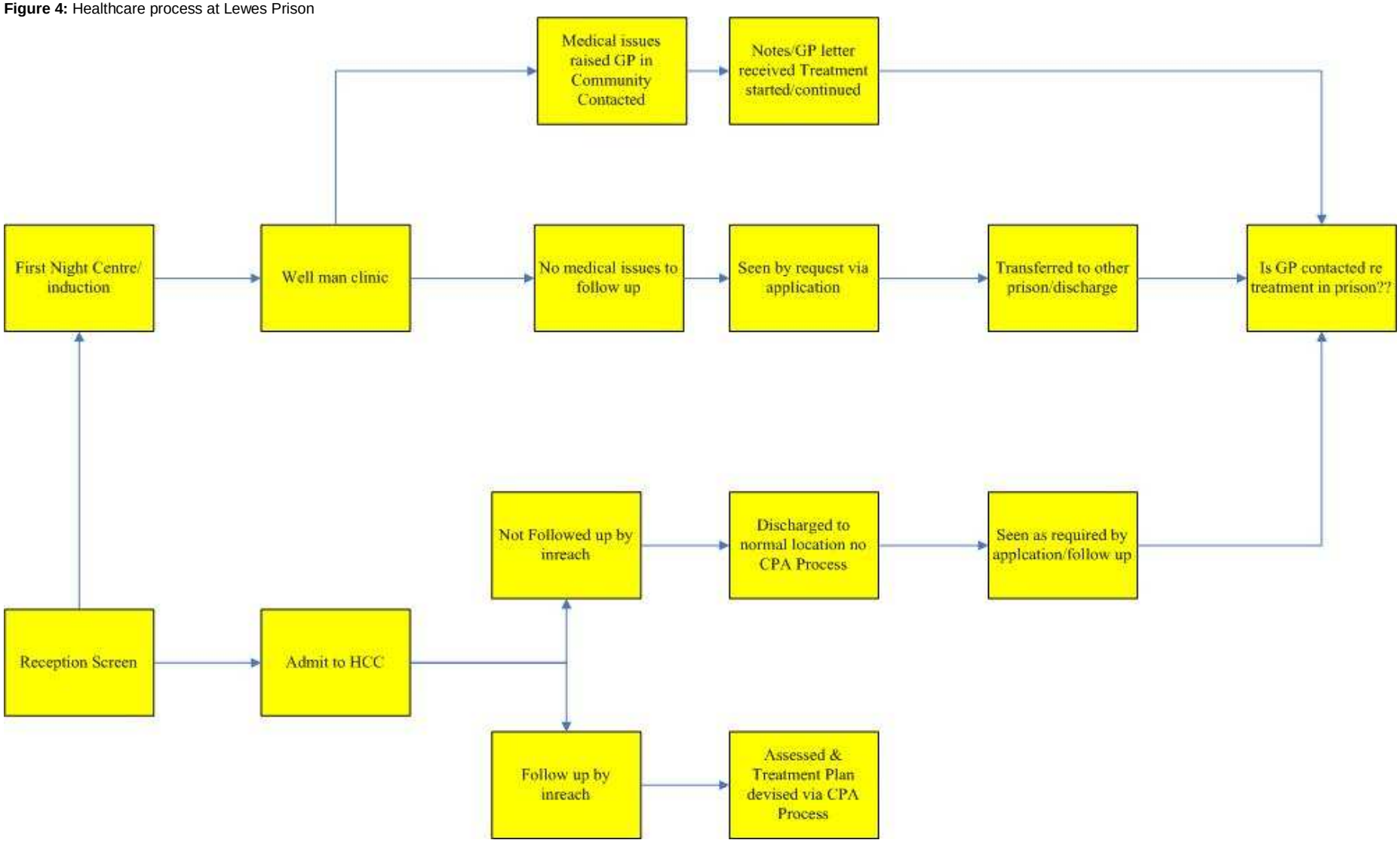
The OPD is led by two whole time equivalent (WTE) Charge Nurses: one lead for the ODP and one for chronic disease management. Table 14 outlines activity data for out-patient services between April 2006 and August 2007.

Table 14: Outpatient activity between April 2006 and August 2007.

	Activity	Number of months data available for	Total number in the 17 months between 4.06- 8.07	Monthly average
Number of patients seen by…	GP	17	5810	516
	healthcare staff	17	20354	1782
	Chronic Disease Management Clinic(s)	5	24	5
	Psychiatrist	17	830	70
	Podiatrist	5	49	10
	Radiographer	4	45	11
	Sexual Health	5	51	10
	HC Counsellor	5	62	12
	for Immunisations	5	750	150
Number of…	dentist sessions	17	371	24
	psychiatrist sessions	17	161	15

Source: HMP healthcare activity data
Note: numbers have been rounded

Figure 4: Healthcare process at Lewes Prison



GP Services

GP services are provided by Sussex Forensic Medical Services. There are five main GPs with support from locums. GPs provide a session in the morning between Monday and Saturday with additional afternoon visits and on-call duties at other times.

Time between referral to GP is approximately one week for non-urgent appointments.

Dental health:

This service is provided by a third party contract, supported by a community dental nurse. Until April 2008 two dental sessions per week were provided, this has subsequently been expanded to three sessions a week and is currently under further review in order to provide further sessions.

Current waiting time is four to six weeks for non-urgent routine care and one week for urgent care. Patients with emergency needs outside session times which cannot be managed by outpatient staff are escorted to the local emergency dental service.

Demand for dental service is high, in part because it is more accessible to inmates while they are in custody, but also because many have poor dental health coupled with long-term substance misuse. Dental hygiene and health promotion remain areas of focus.

Pharmacy service

The pharmacy service is provided by the PCT and comprises a full-time pharmacy service five days a week with one WTE lead/principle pharmacist and 1.5 WTE pharmacy technicians. The service is located in security building adjacent to the healthcare centre.

It is a high demand service, given turnover of the prison and the needs of the client group. Pharmacy staff do not have direct contact with prisoners and in a survey carried out by HM Chief Inspector of Prisons 28% of prisoners felt that the pharmacy service was good or very good, against a comparator of 34%.

Prisoners can hold medication in possession for between one and 28 days. Approximately 35% of prisoners are on medication during any given month (Table 15). A snapshot of prescribing at the end of April 2008 found 51% of whom almost half were receiving medicines supplied in daily packs. The total number of items dispensed during April 2008 was 4,728 of which 2,111 were prepared as daily packs. Approximately 15% were receiving antidepressants; 6% antipsychotic medication; and 2.8% opiate analgesics.

Table 15: Average monthly number of prisoners on daily and weekly treatment, April 2006 – August 2007

Activity		Number of months data available for	Monthly average (4.06 – 8.07)
Number of prisoners on weekly treatment at month end on …			
	all Wings excluding HCC Wing inpatients	16	96
	C Wing	12	33
	A Wing	12	22
	F Wing	12	35
Number of prisoners on daily treatment at month end on …			
	on all Wings excluding HCC Wing inpatients	16	82
	C Wing	12	28
	A Wing	12	20
	F Wing	12	29

Source: HMP healthcare activity data
Note: numbers have been rounded

Medication is a source of continual concern in terms of supply, administration methods, variances with standard chronic disease procedures, vulnerability of nurses on the wings etc. It is also very resource intensive.

Radiography services:
The radiography service is provided by PCT and comprises of two sessions per week. The digital Picture Archive Communication System (PACS) is not currently installed.

When x-rays are required and the on-site service is not available prisoners are escorted to either the Lewes Victoria Hospital or the Royal Sussex County Hospital/Princes Royal Hospital; non-urgent cases wait for the in-house service.

Optometry service:
Optometry services are currently provided by private contractor at one session per fortnight. It is a high demand service with a waiting time of three weeks.

There is currently no diabetic retinopathy screening. However, this is being progressed.

Podiatry service:
The PCT provide podiatry services, currently Band 6 podiatrist provides one session per fortnight. Waiting times are currently four weeks. Diabetic foot care is part of service in partnership with CDM lead.

Counselling service:
Currently no clear contract for counselling service, therefore, one session per week is provided via the PCT bank. There is a current waiting time of four weeks.

Immunisation service:
Immunisation services are provided in hours and offered routinely as part of health screening service and includes Hepatitis B and C, flu vaccine, TB etc. There is currently no waiting time.

Access to treatment for Hepatitis C is key issue as increased screening is identifying larger numbers of prisoners who could benefit from treatment. However, currently treatment is not available within HMP Lewes, although it is available in the community

Sexual Health Services:
Until March 2008 sexual health services were provided in conjunction with the Claude Nicol Clinic at the Royal Sussex County Hospital. This service returned to ESDW PCT as of the first of April 2008 with the Eastbourne sexual health clinic maintaining services in partnership with the chronic disease management lead.

Prior to the change in service provision one session a fortnight was provided in the OPD, average wait times for the service were six to eight weeks. Screening and treatment are offered for sexually transmitted diseases, including HIV alongside pre- and post-test counselling.

Information technology:
The healthcare services at HMP Lewes have access to both prison and PCT intranet systems, internet and relevant database systems.

During 2006 cabling was undertaken to complete installation of the PCT systems as well as cabling for the Phoenix SystemOne, a primary care/GP electronic records system and database. The Phoenix SystemOne is part of the national IT programme, and is due to be installed in all prisons to facilitate sharing of medical records, parity of data and continuity of care as prisoners transfer around the prison estate. It is also compatible with other GP systems.

The system went live at the prison in June 2007. However, although training has been rolled out there are issues around the backlog of information which needs to be entered on to the system before it is used for new prisoners.

Administration and court services

All complaints regarding healthcare at the prison are currently dealt with internally (Table 16). On average there were seven complaints monthly between April 2006 and August 2007. However, from the activity data provided it can not be determined how many individual prisoners registered complaints about the service. No complaints from prisoners are dealt with via the ESDWPCT complaints process currently.

Table 16: Number of complaints and court requests to healthcare, April 2006 – August 2007.

Activity		Number of months data available for	Total number in the 17 months between 4.06- 8.07	Monthly average
Number of…	complaints (local resolution) this month	5	33	7
	complaints (NHS Policy progressed)	5	0	0

Source: HMP healthcare activity data
Note: numbers have been rounded

4.1.3 Secondary care

The hospital wing landing comprises 19 beds over two floors: 14 single cells, one of which is a disabled cell; 2 are safer custody cells; and one constant watch cell. In addition, there is a two bed and a four bed cell. Average occupancy prior to the expansion was on average 77% (15 beds per month), anecdotally this has increased to 90% with 17 or more beds occupied on the wing on a weekly basis.[49] Table 17 details the level of activity on the inpatient wing between April 2006 and August 2007.

Table 17: Healthcare centre inpatient activity, April 2006 August 2007/

Activity		Number of months data available for	Total number in the 17 months between 4.06- 8.07	Monthly average
Total admitted to	prison in quarter	8	5039	630
	Healthcare Centre in quarter	8	296	37
Number of…	inpatients at month end	17	186	15
	admissions this month	17	179	15
	prisoners awaiting mental health transfer at month end	12	6	1
	patients waiting more than 3 months for MH transfer	17	2	0
	ACCT at month end	17	80	6
Average…	occupancy for month	5	73	15
	length of stay (days)	5	81	16
	average daily hours out of cell HCC last quarter	5	47	7

Source: HMP healthcare activity data
Note: numbers have been rounded

The most common reason for admission to the inpatient wing is mental health illness and/or 'self harming' or 'at risk of self-harm' and require 'constant watch' or observation in safer cells. Prisoners with acute physical ill health are transferred to the appropriate external hospital for treatment (see section on bed watch and escorts)

4.2 Mental Health Services

Mental health in-reach service:

Despite the mental health in-reach service being reconfigured in April 2007 primary mental health remains underdeveloped within HMP Lewes.

The caseload of in-reach team is high as there is a large demand for mental health input. Three part-time mental health nurses provide a proactive and therapeutic primary care service on the wings on weekdays. Any member of prison staff can refer a prisoner for

assessment. Written and verbal referrals are assessed and prioritised daily with urgent referrals seen on the same day and routine referrals within one week. Prior to expansion there were approximately 30 referrals a week.

All prisoners sentenced to four or more years, have life sentences or have been charged/convicted for murder are automatically referred to the mental health team for assessment for additional support to minimise risk of self harm, as they are a historically high risk group.

Consultant psychiatric service:
This service is currently provided by Sussex Partnership Trust and comprises of both general and forensic consultant psychiatrist. There are five sessions per week and consultants are supported by Specialist Registrar's and Senior House Officer's. Approximately 30% of prisoners admitted to HMP Lewes in 2006-07 were seen by a consultant psychiatrist. 965 patients were seen in 2005-06 and 851 in 2006-07, the numbers are constrained by prison routine and need for services is higher than recorded numbers.

The wait time between referral and assessment by consultant is two to three weeks. There is currently no support from occupational therapists, psychologists or psychotherapists, nor are there any behavioural programmes.

It has been noted that the number of visiting psychiatrists, the variation in individual working practices and communication issues do not always work in the patients best interest and make day-to-day management of patients difficult.[50]

There is no clinical psychology input.

Inpatient mental health
The inpatient service is staffed 24 hours a day seven days a week and staff provide backup for outpatients department, in-reach mental health and emergencies as required. Admission is through nurse identification of prisoners at reception, from the wings or via the GP. All referrals are assessed by a senior clinical psychiatric nurse.

Table 18 outlines the inpatient mental health service activity for the period April 2005 to March 2007 at HMP Lewes.

Table 18: Mental health activity, April 2006 – August 2007.

	Activity	Number of quarters data available for	Total number between Q1-2005 and Q4-2006	Average per quarter
Number of…	day care places offered on one day at end last quarter	7	0	0
	prisoners referred for assessment for possible mental health transfer in quarter	7	560	78
	prisoners assessed and accepted for mental health transfer by mental health professional in quarter	9	54	6
	mental health transfers in quarter	9	52	6
	prisoners at end of quarter waiting more than 3 months for mental health transfer from date of acceptance for transfer to secure hospital	10	4	0.4
	prisoners in quarter who received a second psychiatric assessment from patient's own PCT	10	1	1
	awaiting second assessment from patient's own PCT for more than four weeks (on day of census).	10	0	0
	those awaiting transfer, after transfer has been agreed, being managed on segregation (on day of census).			
	Self-harm incidents last quarter		410	51

Source: HMP healthcare activity data
Note: numbers have been rounded

The report of an unannounced visit to HMP Lewes by HM Chief Prisons Inspection Officer it was noted that the inpatient facility was well staffed and provided a clean and pleasant environment but patients had restricted movement and did not receive enough purposeful activity.

An identified gap within mental health services is the lack in the provision of learning disability-trained nurses.

4.3 Services for alcohol and drug misuse

4.3.1 Substance misuse services:

The substance misuse service (SMS) is commissioned from Sussex Partnership's Trust providing 2WTE substance misuse nurses. However, the process of transferring the responsibility of the service and employment of staff to the PCT is currently underway.

The prison has its own Prison Addressing Substances Related Offending (PASRO) service, a cognitive programme focusing on mainly poly-substance misuse. Alcohol focused programmes are to be provided soon. The service works closely with SMS and the Counselling Assessment Referral Advice and Through-care service (CARATS), which also cover the community on release.

There is a 29-bed detox wing. Prisoners requiring access to the unit undergo a comprehensive assessment by a substance misuse nurse at reception and a GP assessment the following morning, they are then transferred to the unit where reduction and stabilisation regimes are commenced. Comprehensive clinical management protocols have been developed.

Methadone and Subutex are the primary drugs used for detox and maintenance. There were 528 drug-detox programmes undertaken in 2005-6 increasing to 576 for 2006-07, with an average of 43 per month, approximately 20% of admission during 2006-07. There were 204 alcohol detox programmes undertaken in 2005-06 with 207 in 2006-07, a monthly average of 17% (Table 19).

Table 19: Detoxification activity, April 2006 – August 2007.

Activity		Number of months data available for	Total number in the 17 months between 4.06- 8.07	Monthly average
Number…	of drug detox started	17	613	49
	of alcohol detox started	16	182	18
	on maintenance prescriptions…	1	31	31

Source: HMP healthcare activity data
Note: numbers have been rounded

Mandatory and voluntary drug testing is carried out at the prison. Reception testing has shown that 50% of new arrivals have used drugs prior to custody, reflecting the high level of problematic use in the local population. The 2007 mandatory drug testing (MDT) positive rate stood at 11% in August 2007, against a target value of 15% and a 2006 level of 16%.

Links with the prison CARATs team and throughcare links with community providers enable prisoner release plans to be developed and maintenance programmes for opiate users to be continued upon release.

HMP Lewes has been identified as part of the 2008-09 roll out for the Integrated Drugs Treatment System (IDTS) which aims to expand the quantity and quality of drug treatment in HM Prisons by:

- Increasing the range of treatment options available to those in prison, notably substitute prescribing;
- Integrating clinical and psychological treatment in prison into one system that works to the standards of Models of Care and the Treatment Effectiveness Strategy and works to one care plan ; and
- Integrating prison and community treatment to prevent damaging interruptions either on reception into custody or on release back home.

In order to establish IDTS programmes a local implementation team, which as a minimum requires membership of the establishment, the local drugs partnership and the PCT responsible for commissioning healthcare services in the prison, in order to monitor the implementation process and to develop an annual IDTS needs assessment process to facilitate the identification of the priorities for integrated drug treatment plan.[51,52]

4.3.2 Alcohol services:

Work with offenders with alcohol related problems is limited. Two nurses provide clinical treatment and the Crime Reduction Initiative (CRI), who are funded to provide support for illegal drug misusers, work with poly drug misusers, for whom alcohol is often a second drug of use. There is however, no formal support and on release, there is no referral system to support services.[53]

4.3.3 CARAT service

The CARAT service (Counselling, Assessment, Referral, Advice and Through-care) was established in 1999 as a universal drug treatment service in every prison establishment across England and Wales. CARAT services are a major element of the Prison Service Drug Strategy. Prisoners can be assessed by a CARAT team, given advice about drug misuse and referred to appropriate drug services. CARAT workers may also offer counselling and group work to prisoners who want to stop misusing drugs. CARAT services include needs assessment and care planning. They are provided chiefly by external drug agencies, prison officers and healthcare staff working in partnership.

The CARAT service in HMP Lewes is provided by Crime Reduction Initiative (CRI). The CARAT team visit prisoners on the detoxification wing daily as well prisoners on other wings.

4.4 Healthcare escorts, bed-watches and constant watches

Healthcare escort is the terminology used to describe attendance at an outside hospital for a planned appointment. Escorts also include transfer of prisoners from healthcare to an appropriate secure forensic unit under section & warrant as these require a registered mental health nurse to escort them.

Almost half (45%) of all booked/planned appointments at HMP Lewes are cancelled; the main reason for cancellation are lack of prison staff for escort (25%) and prisoners being transferred prior to the appointments date (21%) (Table 20). Cancellation by the NHS and prisoners declining appointments are also important (18%).

Table 20 : Number of cancelled appointment by category, April 2005 – March 2007.

Activity		Number of quarters data available for	Total number between Q1-2005 and Q4-2006	Proportion of all cancelled (%)	Average per quarter
Number of escorts cancelled:	Total	8	374		47
	Declined by prisoner	8	67	17.9	8
	Security reasons	8	10	2.7	1
	Staff shortages	8	99	26.4	12
	Prisoner transferred	8	78	20.8	10
	Cancelled by NHS	8	67	17.9	8
	Other	8	53	14.2	7

Source: HMP healthcare activity data
Note: numbers have been rounded

Between April 2005 and March 2007 there were 823 external escorts arranged for healthcare treatment, of these and average of 3 per month resulted in an external stay of greater than one night (Table 21).

Table 21: Escort and bed-watch activity, April 2005 – March 2007.

Activity	Number of data months available for	Total number between Q1-2005 and Q4-2006	Average per month
Number of external escorts arranged for healthcare treatment (including escorts turned into bed-watches)	25	823	34
Of these, number of bed-watches of more than one night's duration	25	76	3
How many external escorts were for urgent purposes/were not pre booked?	25	42	2

Source: HMP healthcare activity data
Note: numbers have been rounded

Bed-watch is the terminology used by the prison to describe when a prisoner is required to remain at least overnight in a hospital outside of the prisons healthcare centre. The prisoner is usually escorted by two prison officers. These can be planned, but are often the result of an emergency. During the period April 2006 to August 2007 there was a total of 6691 bed-watch hours accumulated, an average of 393 hours (approximately 16 days) per month.

'Constant watch' is the terminology used to describe a 1:1 supervision of a prisoner who is at high-risk of self-harm. Between April 2006 and August 2007 the average number of prisoners on constant watch during any given month was four.

4.5 Health promotion and health education

As there is a responsibility to ensure that prisoners have access to health services that are equivalent to those the NHS provides to the wider population prisons should provide health education, patient education, prevention and other health promotion interventions.[54] Prison can provide a key role in providing people with healthcare that they might not otherwise receive in the wider community and the Government's programme for tackling health inequalities recognises that prison is an important setting for health promotion activities.[55]

The World Health Organisation recommend a 'whole institution' approach to health promotion in prisons, stating that: *"the target audience is not only prisoners, but also staff, prisoners' families and local communities".* To be effective health promotion should be built into every branch of prison management to create a climate for improving health

using a three pronged strategy: creation of 'healthy policy', health promotion and health education.

- Healthy policy: e.g. anti-bullying; induction programme; providing access to education, training and job skill development.
- Health promotion: specific campaigns – smoking cessation/ exercise programmes; preventative services – drug minimisation.
- Patient education: health education to promote a healthy lifestyle through planned interventions can be supported by all staff, not just health professionals.
- Prisoner's self perceived needs: what areas of their own health are prisoners most interested in learning about/ changing?

Healthy Prison Concept: in 1999, the Prison Inspection introduced the concept of the Healthy Prison, and assesses and tests prisons against four criteria. The four criteria of a healthy prison are:

- Safety Prisoners are held safely (includes preventing bullying and self-harm);
- Respect Prisoners are treated with respect;
- Purposeful Activity Prisoners are able, and expected, to engage in activities that are likely to benefit them;
- Resettlement Prisoners are prepared for their release into the community and helped to reduce the likelihood of re-offending.

The August 2007 unannounced inspection visit report by the HM Chief Inspector of Prisons highlighted that the level of health promotion activity within the prison was inadequate. Although all new arrivals are given a full health check there is no well-man clinic nor is there any dedicated care of older prisoners (those aged over 60)

Smoking cessation services:
Nationally it is estimated that approximately 80% of prisoners smoke, in the 2004 HCNA audit of inmate medical records 70% of prisoners were recorded as smoking between ten and forty cigarettes per day. Smoking cessation courses are run by trained OPD/healthcare staff and there is a high demand for this service. During the period April 2006 to August 2007 an average of 15 prisoners started on a smoking cessation course, with over 50% competing the course (Table 22)

Table 22: Number of prisoners starting and completing smoking cessation courses at HMP Lewes, April 2006 – August 2007.

Activity		Number of months data available for	Total number in the 17 months between 4.06- 8.07	Monthly average
Number of…	patients started Smoking Cessation Course	4	61	15
	patients completed Smoking Cessation Course	4	30	8

Source: HMP healthcare activity data
Note: numbers have been rounded

Prison officers are currently undergoing training to enable them to facilitate smoking cessation courses for prison-employed staff.

4.6 Service costs

Financial responsibility for commissioning prison health services transferred to ESDW PCT in 2005. Guidance and prison health budget allocations are received from the joint Department of Health and Prison Service Offender Health (formerly Prison Health) team.

Table 23 outlines the summary of services required within HMP Lewes and potential costs.

Awaiting updated budget breakdown
Summary of required resources

Table 23

	Service	Post		WTE	Number sessions	Costs 08/09 (£ '000)	FYE 09/10 (£ '000)
1	Inpatient	HCA	Band 3	5.0		99	
		RN	Band 5	5.0		138	
2	Outpatient	HCA	Band 3	1.0		20	
		RN	Band 5	6.0		168	
3	Dental	Dentist			3	36	
		Nurse			3		
4	Optometry	Optometrist			1	11	
5	Podiatry	Podiatrist			1	4	
6	Counselling	Counsellor	Band 6	0.5		18	
7	Pharmacy	Pharmacist	Band 7	1.0		41	
8	Sexual health				6	36	
9	Admin	Administrator	Band 3	1.0		20	
		Administrator	Band 2	0.5		4	
10	X-Ray	Radiographer	Band 6	TBC		9	
11	Porter	Porter	Band 2	2.0		36	
12	Dietetics	Dietician			1		
13	Housekeeping	Housekeeper	Band 2		5		
14	Information Technology						
15	Psychiatric Services				5		
16	GP services				10*	149	
17	Mental Health	Occupational Therapist	Band 6	1.0		18	
		Clinical Psychologist	Band 7	1.0		23.5	
		RMN	Band 5	3.0		42	
18	Substance Misuse		Band 5	3.0		42	
		Head of service	Band 7/8A	1.0			
		Deputy head of service	Band 7	1.0			
19	Non pay – non drugs related budget					70	
20	Drugs budget					50	
	Total			32	35	1 034.5+	1 202.5+

*approximation based on: 1 further session per day seven days a week and additional five hours in evening

5. Service user and provider views

5.1 Service users

Within the NHS patients increasingly play a part in assessing the quality of care. [56] Section 11 of the Health and Social Care Act 2001 (now S242 of the consolidated NHS Act 2006) places a duty on NHS trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in service planning and operation and in the development of proposals for changes.[57]

This duty extends to prisoners and is recognised in the 'service user involvement' health performance indicator which states that prisons must ensure 'the views of service users, their carers (including prison staff) and others are sought and taken into account in designing, planning, delivering and improving healthcare services. Formal procedures are in place to ensure involvement and such involvement is documented accordingly'.[58]

In April 2008 a group of 15 prisoners, representing all wings, were invited to take part in a health focused 'prison forum' which involved staff representation from the prison and healthcare. The facilitated day aimed to give prisoners the opportunity to discuss healthcare services within the prison, highlight areas of dissatisfaction and suggest possible solutions to problems. Healthcare and management representatives were also given the opportunity to share information and respond to areas highlighted by prisoners.

Key suggestion were rated by prisoners for importance and then by healthcare and management importance and achievability. Nineteen areas were identified with prescribing policies; outside appointments; the role of prisoner Listeners; and access to smoking cessation services ranking highly (see Appendix 2 for full list). These areas were highlighted for action.

5.1.1 Prescribing policies

The removal of prescription drugs upon arrival was highlighted as an ongoing issue. Prisoners arriving from courts, police custody, other prisons, or from external NHS appointments have all prescription drugs removed from their persons at reception and must wait until they are seen by a GP who then re-prescribes where considered clinically appropriate.

It was highlighted that the delay between reception and having a prescription filled can be many days which can lead to distress and concern amongst prisoners. Delays in receiving anti-depressant medications were particularly highlighted, as was the removal of ventilin inhalers for asthmatics. Prisoners acknowledged that pain relief medicines, especially opiate-based pain relief, were problematic for the prison service, but queried policies on other substances and the delays involved in receiving replacement prescriptions within the prison.

Action:

- Nurse prescribing to be introduced at reception to reduce wait times for medicines prescriptions.

5.1.2 External specialist appointments

The difficulty of getting access to specialist appointments and the frequent cancellation of outside appointments was a major area of concern for prisoners. Prisoners felt that appointment cancellations and delays in arranging appointments were a significant cause of ongoing stress and anxiety and often limits individual's quality of life and their ability to engage in daily activities (work; gym etc.)

Reasons given for prisoners having appointments cancelled included: not enough staff to take prisoner offsite; lockdown; clashing with family days etc. Frustration was voiced

that manpower was found to cover emergency transport requirements, but that elective scheduled appointments cannot be covered. Prisoners felt that the 'duty of care' that the prison service and NHS had towards them was not taken seriously.

Action:

- Prison and healthcare staff to co-ordinate better to ensure outside appointments are kept.
- Healthcare to introduce 'receipt' system to let prisoners know that specialist appointments have been made (with no date or time information in accordance with security measures).

5.1.3 Smoking cessation

Although smoking cessation services are available and highly valued by prisoners access is an issue. The wait-time for accessing smoking cessation courses can be as long as four months as courses are run sequentially through each of the wings.

Action:

- Increased training of smoking cessation for staff in order to meet demand.

5.1.4 Prisoner Listeners

Effective peer support can contribute to creating a safe, decent and healthy environment with positive prisoner-prisoner and staff-prisoner relationships, where problems can be voiced and addressed and anxiety alleviated. Listeners provide confidential emotional support to other prisoners. The support offered by Listeners is confidential, so that details of a prisoner's conversation with a Listener will not be passed on to prison staff unless the person they are supporting gives their permission.[59]

The presence of Listeners is highly valued by prisoners, but the prison expansion has resulted in Listener availability to be limited. Additionally, it was felt that some prison officers did not respond in a timely or appropriate manor to Listener concerns about other prisoners, including opening Assessment, Care in Custody and Teamwork (ACCT) plans and allowing access to those being supported on other wings. ACCT plans encourage staff and prisoners to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

Prison officers highlighted a need for increased mental health training for staff to improve identification of prisoners with extra support needs.

Action:

- Increase number of Listeners to ensure all wings, including the first night centre, have a Listener.
- Increase staff training on the role of the Listener and their responsibility in responding to their concerns.
- Increased mental health awareness training for prison staff.

3.1.5 Other issues

In addition to the areas ranked by prisoners and staff other areas of discussion included:

- Induction: A formal health induction in which the healthcare services available and how to access them were explained was suggested as an improvement over leaflets which may or may not be read.

    - GP service: Although not identified as an area of high priority by prisoners, the lack of continuity of care as a result of no consistent GP input into primary care was raised. Prisoners felt that the differing practices of GPs

entering the prison resulted in a 'pot luck' approach to how health concerns were treated in a consultation. The wait time for seeing a GP is such that prisoners felt some prisoners were not making appointments for acute illness in the belief it will clear-up before they get to see a GP.

The majority of prisoners present agreed that generally there was a 'fear of getting ill in prison' and that there was no equivalence with healthcare services outside the prison.

- Dental service: Problems with accessing dental services, both within the prison and specialist services outside the prison were highlighted. It was acknowledged that this has been particularly difficult recently due to staff sickness, but although dental provision has recently been increased it was felt it was still insufficient to meet the needs of the population.

- Optometry service: Limitations on optometry service availability were also discussed. There appeared to be confusion amongst prisoners and staff in regards to the perceived pre-requisite of having to have served more than four months but have more than six months left to serve before being able to access the optometrist. It was perceived that waiting times for this service are very long which meant simple repairs could be substantially delayed.

- Segregation unit: Concerns were raised that some prisoners on the segregation wing had mental health needs that were not being addressed.

- Lifestyle issues: The decrease in the number of gyms sessions was highlighted particularly by younger prisoners. Currently gym availability has been curtailed in order to provide taught sessions.

  Prisoners were generally happy with the food they receive. All were aware of the healthy choices and special meals available, and suggested further nutritional information would be appreciated.

5.2 Service providers

Representatives from a range of healthcare services were interviewed to obtain their views on a number of areas: the level and structure current service they provide; challenges of working in the prison environment; and views on how services could be better provided in the future.

Service providers interviewed were positive about the changes to healthcare services which have occurred since the transfer of responsibility to ESDW PCT but identified a number of core and service specific areas which need to be addressed.

5.2.1 Core issues

The core issues raised by service providers were mainly related to the structure and functioning of services and included: lack of clarity in regards to commissioning processes; training and development opportunities for staff including PCT and HMP Lewes induction courses; and staffing levels.

The lack of clarity in commissioning processes for healthcare services was raised by both staff based within HMP Lewes and service providers who enter the prison as visitors. The absence of clear service level agreements and the ad hoc nature of provision by many services resulted in many interviewees questioning whether the current services are meeting the true healthcare needs of the prison population.

Training and development was raised by staff working within the prison. Although opportunity to attend training courses/sessions has improved since the employment of

staff by the PCT it was felt that opportunities were not equally available to all staff and that staffing pressures in some areas made it difficult for individuals to attend courses even when available. The absence of PCT induction was highlighted by many staff employed within the prison, while services entering the prison on an ad hoc basis identified lack of induction/training in the prison itself as a limiting factor.

Staffing levels were also an area of concern: the lack of access to appropriately trained bank staff; delays in the recruitment process; and a sense that numbers of staff were insufficient to meet the level of need, especially in light of the current expansion process contributed to this.

5.2.2 Area specific issues

Physical health

Areas specific to physical health services included:

- Lack of appropriate consultation space for healthcare including concerns regarding patient privacy and confidentiality;
- The limitations of IT infrastructure and training;
- The absence of prisoner self-care opportunities, including medicines management;
- The level of dental service input;
- Access to hepatitis C treatment;
- Continuity of care, including arrangements for liaison with specialist healthcare services outside the prison for support for the care of prisoners with specific needs.

Mental health

Mental health services within the prison are in a transitional phase, the recent employment of senior clinical staff is considered to be an opportunity of reorganise and streamline services. Areas highlighted by staff include:

- Continuity of care from specialist psychiatric services, including information sharing with the inpatient team;
- The lack of therapeutic opportunities for prisoners on the inpatient wing;
- The limited ability of the in-reach service to meet demand for assessments;
- The lack of services available for: neurotic disorders, such as depression and anxiety; personality disorders; and for learning disability;
- Workload and staffing levels on the inpatient wing.

Substance misuse

The recent confirmation that HMP Lewes will be included in the 2008-09 roll-out of the IDTS programme is now the key focus for substance misuse services within the prison. Support for this from both ESDW PCT and HMP Lewes management is required to ensure smooth implementation.

Information sharing with other healthcare services was suggested as one area to be improved on.

Allied healthcare services

All representatives from allied healthcare services involved in providing care to prisoners underlined the importance of formalised agreements for the provision of care. All service currently respond ad hoc to referrals and requests for treatment and this is considered unsatisfactory for ensuring appropriate therapeutic and rehabilitative care for individuals and for meeting the overall need for services within the prison population. All service suggested formal arrangements for provision of dedicated in-house sessions that would be better able to achieve results for individuals and meet the level of need which is assumed to exist.

Although staff and service providers recognised that the challenges of working in the prison environment are directly related to limitations of current service provision there was a great deal of optimism regarding the future of services and the ability to meet the health needs of prisoners in a more systematic and satisfactory manor.

6. Effectiveness of Services

PCTs responsible for prisons have a commissioning duty to ensure that as far as possible, given the constraints of the prison environments, prisoners have access to healthcare services which are comparable to those available in the local community and these services are appropriate to their needs.[60] Prisoners should be cared for be a health service that assesses and meets their needs while in prison and which promotes continuity of health and social care on release.[61,62] The underpinning ethos for providing prison health services is that they are delivered with decency and respect, by appropriately trained and well supported staff adhering to professional and ethical codes of practice, and provided in a clean environment that offers safety and privacy.[63]

Health care organisations in prisons face a number of potential difficulties in delivering good quality care. Challenges include working in a culture where health care provision is not the predominate concern.[64] Problems with recruitment, high turnover, effective leadership and professional isolation are a direct result of these challenges

In order to continue to deliver high quality care, staff should be equipped with the appropriate skill set and knowledge for the roles they fulfil. In order to achieve this healthcare service providers must ensure:

- All healthcare staff are required to be appropriately trained and, where relevant, properly qualified and registered with the appropriate regulatory body to provide care to a professional standard of practice.
- Healthcare staff receive the ongoing training and development they need to maintain professional standards.
- Continuing professional development activity are fulfilled as a matter of good practice and where necessary to maintain accreditation/ registration with relevant professional regulatory body.
- Clinical supervision, provided by appropriately qualified professionals, is available to all nursing staff. [65]

Alongside the duty to ensure appropriate healthcare for prisoners, there are public health and social benefits in providing targeted services related to, for example, substance abuse, mental health, sexual health and harm reduction.

6.1 Reception screening, induction and health assessment

Mandatory guidance states all newly received prisoners must undergo an initial assessment of their healthcare needs within 24 hours of first reception to identify any existing problems and to plan any subsequent care.[66] A reception health screen is a structured process which aims to detect any immediate physical and mental health problems, significant drug or alcohol abuse or any risk of suicide and/or self-harm.[67] Where immediate health needs are established prisoners should be referred to an appropriate healthcare worker or specialist team.

There must be systems in place within the prison to provide relevant information about receptions to other departments.[68] Induction needs to build on the reception process. Good communications between reception and induction staff is essential in order to ensure a smooth transition. It is recommended that there is a formal handover procedure from reception to induction to avoid any part of the reception process being duplicated or missed.[69]

In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community and should act as an opportunity for: gathering further medical information; checking how the prisoner is settling in; health education; providing information; and health promotion.

6.2 Primary Care

Primary care has a key role in acting as the gateway for managing the interface with other services such as mental health services, and in ensuring the whole system of health care in a prison works as smoothly and effectively as possible for the benefit of the patient.

To avoid inequalities in service delivery, care provided must be based on agreed standards and protocols. *Developing and Modernising Primary Care in Prisons* outlined the framework for the development of primary care within prisons. It states that the standards of care provided should be equivalent to those for the general population, namely the national service frameworks for diabetes, coronary heart disease & long term conditions, clinical guidelines issued by the national institute for health and clinical excellence and the quality and outcomes framework for general practice.[70]

Good primary care requires good supporting infrastructure. Without such basics as modern reliable information and IT systems and safe, fit for purpose facilities, without which the development of primary care may be impeded. [71]

6.2.1 Chronic disease management

The management of chronic illness and disease in the population as a whole are current priorities within the NHS. The move to mainstream or normalise care in prisons assumes that prisoners should receive the same standard of care that they receive outside prison.[72]

It is assumed that for the clinical management of prisoner health problems, unless proven otherwise, that a normal approach will achieve normal outcomes.[73] There is evidence for the poor health status of older male prisoners, for the high prevalence of some chronic diseases such as asthma and that hypertension may be more prevalent in prison populations compared to outside control groups, rising with length of time incarcerated.[74,75,76,77] However, the published evidence about service provision within the prison environment for most individual diseases is limited.

6.2.2 Older prisoners

In the UK general population the number of people aged over 65 is predicted to rise by 15% and by 27% among those aged over 85 by 2010.[78] More than 1000 prisoners aged over 65 years leave prison each year.[79] Older prisoners experience accelerated ageing, which means that they may experience issues associated with older age from 50 years old.[80] Prison population trends for England & Wales (1996-2007) reveal that numbers of men aged over 60 trebled over the past decade, compared to a one and half times increase among the 18 to 59 age group.[81]

In 2004 two major reviews examined the healthcare needs and services available for older prisoners in the UK.[82,83] These reviews have increased awareness that demographic changes in the general population and sentencing policy are set to bring about significant changes to the age profile of all prisons.

Services available to the general population such as screening, health promotion, chronic disease management, podiatry, audiology, optometry and dentistry are currently under-developed in many prisons.[84,85,86] The review '*No problems – old and quiet: Older prisoners in England and Wales*' was set against relevant NSF targets and highlighted gaps and failings in services provided for older prisoners (Table 24).[87]

Table 24: NSF for Older People standards applicable to prison setting with findings from 'Old and Quiet review'

NSF for Older People	Old and Quiet
NSF 1: NHS services will be provided, regardless of age, on the basis of clinical need	"In general, older prisoners pose no control problems for staff. But, because of that, prisoners' own problems, particularly as they grow older and less able bodied, can easily be neglected."
NSF 2 – NHS and Social Care services will treat people as individuals… through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services	"Healthcare centres in prisons have the potential to provide the equivalent of community based services meant to promote rehabilitation and independence. Our survey of healthcare managers revealed that, in the majority of cases, this potential remained unrealised. There are few links with community services and a lack of access to aids for daily living….. Healthcare staff relied on informal contact with community services, rather than make formal loan arrangements"
NSF 7 - Older people who have mental health problems have access to integrated mental health services, provided by the NHS…to ensure effective diagnosis, treatment and support…	"The resettlement services … were open to prisoners regardless of age, but courses were geared to the rehabilitation of younger prisoners, with no account taken of the need for older prisoners to manage, often by themselves, with disability or illness, loneliness and isolation. There were no good courses in preparation for, or continuation of, retirement, or to assist in the maintenance of good physical and mental health …"
NSF 8 – The health and well being of older people is promoted through a co-ordinated programme of action led by the NHS…	"Exercise was often the only time of the day when retired prisoners could regularly get fresh air. However, insufficient seating lack of warm clothing and the inability to return to the wing until the end of the exercise period were disincentives to many older prisoners."

Source: CSIP South West. 2007.

In light of the 2004 reviews a subsequent toolkit for good practice was developed. [88] The key recommendations for ensuring that the toolkit for good practice is able to make a real difference in improving care for older prisoners include:

- This toolkit for good practice is adopted and informs policy.
- Each prison should have an older prisoner's policy, with a designated policy lead.
- Protocols should be in place to inform the process for providing regular assessment and care planning for older offenders.
- A nominated or identified key worker within the main prison should ensure that care plans are realised.
- There should be a clear communication strategy between the health care unit, Offender Manager Unit and prison management.
- There needs to be effective inter-agency co-operation between the prison, Offender Manager Unit, primary health care, social services, and community and voluntary support agencies to facilitate a sustainable return to living in the community.
- Training and supervision, for those who fulfil the key worker role, should be available and accessible.
- Training should involve specialists from health and social care.

6.2.3 Communicable disease

Prisons must ensure that they have arrangements for the prevention, control and management of communicable diseases including a written communicable disease policy covering at least: an action plan in the event of a communicable disease outbreak; arrangements for notifiable disease notification; immunisation policies and practice (e.g. hepatitis B); and post exposure prophylaxis protocols.[89]

Health protection activities such as screening and immunisation programmes are a core part of providing a good public health service.[90] As with the treatment of communicable disease in any setting, action for the primary and secondary prevention of disease including appropriate contact tracing, must also be part of an effective service.

Tuberculosis

The clinical guidelines for diagnosis and management of tuberculosis included the following recommendations for providing healthcare in prisons:

- Healthcare workers should be aware of the signs and symptoms for active TB and awareness of signs and symptoms should be promoted among prisoners and prison staff.
- Prisoners should be screened for TB by:
    - a health questionnaire on each entry to the prison system,
    - for those with signs and symptoms of active TB, a chest X-ray, and three sputum samples taken in 24 hours for TB microscopy.
- All prisoners receiving treatment for active or latent TB should receive Directly Observed Therapy.
- Continuity of care should be ensured prisoners are transferred between prisons and for those subject to early release.
- Early discharge planning for prisoners receiving treatment should be arranged to ensure continuity of care
- Provide pre- and on-employment screening at the same level as for healthcare workers for prison staff and others who have regular contact with prisoners (for example, probation officers and education and social workers).[91]

Hepatitis
Hepatitis B (HBV) and hepatitis C (HCV) are of particular interest in the prison populations as prevalence rates for these diseases are higher within prison populations than in the general community. In an unlinked questionnaire and antibody testing study of almost 4000 prisoners in the UK 8% positive for anti-HCV and 7% for anti-HBV.[92] It was prisoners with known risks: men who have had sex with men within prison; and injecting drug users (IDU) who were the most likely to have antibodies to these infections.

HBV
Around one in five injectors have been infected with hepatitis B, and new infections are continuing to occur. Immunisation against hepatitis B is recommended for all sentenced prisoners and all new inmates entering prison.[93] In England, the majority of prisons offer vaccination and it is an effective way of vaccinating this hard-to-reach population.[94] Statistical modelling has shown that if 50% of prison receptions were vaccinated from 2006 onwards, the estimated number of acute hepatitis B in the injecting drug user population may be reduced by almost 80% by 2016. [95]

HCV
Although the prevalence of HCV is low in the general population of the UK, estimated at 0.5% of the population, the prevalence in intravenous drug users is over 50%. HCV infection leads to significant morbidity and mortality from complications of end stage liver disease. Prisons can contribute to the control and management of HCV by acting to:

- Promote of health alternatives to injecting and harm reduction measures to reduce transmission;
- Improve access to treatment and care and increase awareness of risks, consequences, treatment and care opportunities;
- Reduce harm of injection drug use through the provision of adequate substance and alcohol misuse services. [96]

NICE Health Technology Assessment on treatment of HCV identified treatment of mild and moderate HCV as beneficial.[97] However, the regular movement of prisoners between prisons limits access to ongoing specialist medical review. To comply with *Choosing Health* priorities for improving access to healthcare for prisoner's prison services must ensure there are robust systems for the provision of continued care for prisoners following release or transfer.[98]

6.2.4 Sexual Health

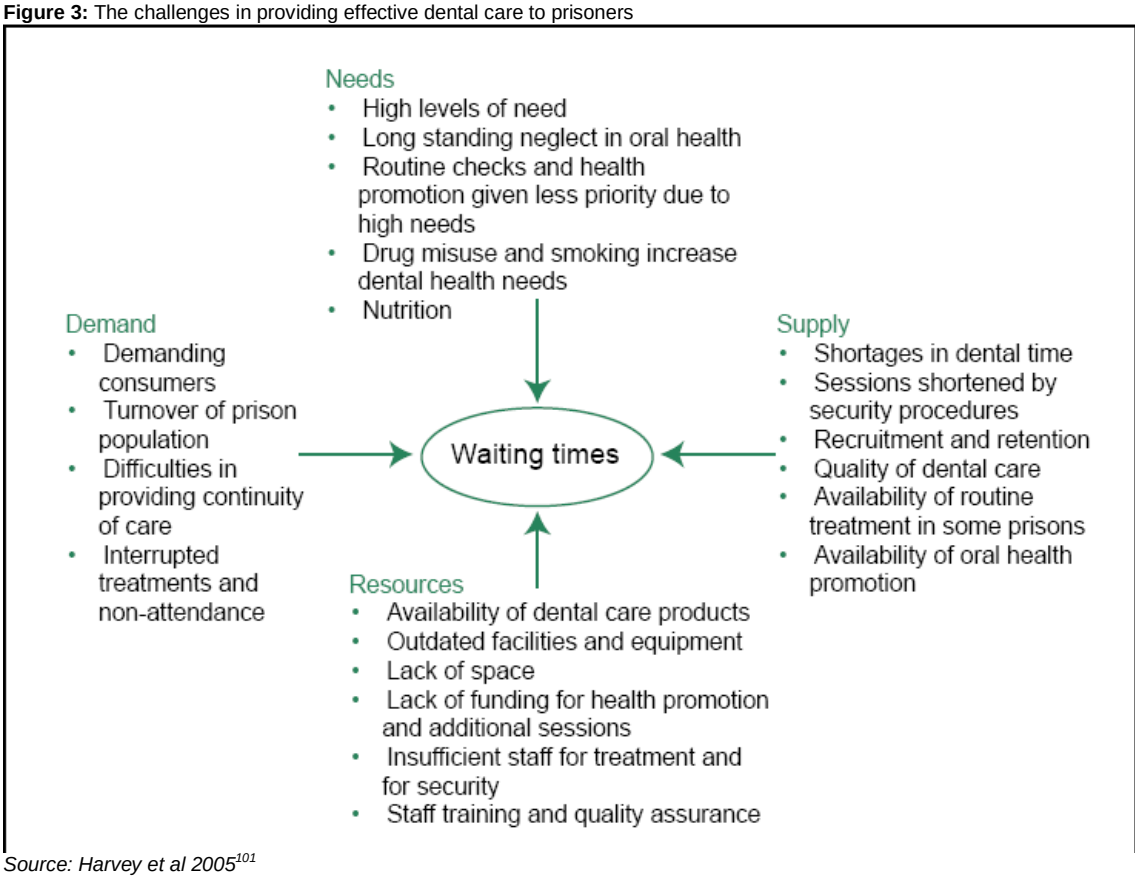
Providing specific sexual health education programmes such as: condom promotion, STI awareness, and wider negotiation and relationship skills to individuals whilst they are incarcerated represents an opportunity to address behaviours that pose a high risk of STI transmission with proven, easy and cheap harm-reduction measures. Adopting a 'healthy prison' approach to sexual health services by providing screening, treatment, and learning opportunities prisoners can not only improve their physical sexual health, but also offer them the opportunity to develop healthy sexual behaviour that can be taken back into the community upon release.

Recommended standards for sexual health services were developed in 2005.[99] There are a number of key evidence-based interventions which are relevant to providing sexual health services within prisons. These include: risk assessment and sexual history taking to assess prisoners STI and BBV risks and the need for screening. Education and support of those diagnosed with an STI or BBV, to minimise the risk of transmission or further infection. And shared decision-making between professionals and individual service users which can result in better health outcomes

6.2.5 Dentistry

Providing prison dental services are challenging: high needs and demands; and limited supply and resources combine to ensure waiting times are long and satisfaction is low (Figure 3). Prisoners are an at risk group who are likely to have diets high in sugar, poor oral hygiene levels and much higher levels of tooth decay than the general population.[100]

Figure 3: The challenges in providing effective dental care to prisoners



Source: Harvey et al 2005[101]

The 2003 Strategy for Modernising Dental Services for Prisoners in England was issued as a prison order and focuses on improving dental services and improving oral health in

the prison setting. [102] The strategy identified three areas of action for healthcare providers to reform prison dental services:

- Identify operational issues and resources needed to meet dental needs, with a view to promoting the commissioning of cost-effective services;
- Each prison is expected to have a robust, costed dental action plan to direct this modernisation; and
- Treatment according to patient need, be prevention focused, be equitable with the service provided by the NHS.

The 2003 good practice guide for reforming prison services highlights four areas of good practice:

- Oral health needs assessment;
- Oral health promotion;
- Improving access to treatment; and
- Improving quality of care.[103]

Choosing better oral health: an oral health plan for England aims to focus prison dental services on preventive care and to promote oral health and general health in order to reduce oral health inequalities.

6.2.6 Pharmacy

The contents of the prison service instruction *'A Pharmacy Service for Prisoners'* outlines the framework for prison pharmacy services stating that the pharmacy services that prisoners receive should be patients focused, reflect identified needs and support and promote self care.

It set out 30 recommendations regarding pharmacy services including the recommendation that medicines in use should normally be held in the possession of prisoners unless there are clearly indicated individual factors why this should not be the case.

Specifically in terms of pharmacy services it stated that the key essentials are:

- A more patient-focused pharmacy service, based on identified patient needs;
- A pharmacy service that is more accessible to the patient, and which enables direct contact between patients and pharmacy staff;
- A pharmacy service which supports self-care and patient self-management
- A more efficient service delivery system, in particular in the supply of delivery medicines;
- A service that utilises the full range of skills and expertise of pharmacy staff; and
- Integration of pharmacy services into the overall delivery of health care services e.g. pharmacists running minor ailment and general medication advice clinics.

6.3 Mental Health

Achieving equality of care for mental health services within prisons with community services will require massive investment in a 'stepped care' model of services, from good quality primary care for prisoners with depression and anxiety to more specialised services for those developing more severe problems.[104] The national strategy for developing and modernising mental health services in prisons set out the challenges and difficulties developing effective and appropriate mental health services in prisons.

The level of need is very high – surveys conducted by the Office for National Statistics in 1997 indicated that nine out of every ten prisoners have at least one of the five disorders considered in the survey (neurosis, psychosis, personality disorder, and alcohol abuse or drug dependence). It is known that prison is not conductive to good health; with the rules and regimes that control daily living, restrictions on activity and poor mental healthcare many prisoners can expect their mental health to deteriorate

further.[105,106] Additionally there is considerable variation in the delivery, quality and effectiveness of prison healthcare, facilities are often poor, staff numbers were low and many are not sufficiently trained.[107]

The national prisons mental health strategy outlines six key recommendations to bring prison services in line with the seven standards of the NSF for mental health.

- Redirect resources to increase and improve day-care and wing-based service in order to reduce the number of inpatient cases;
- Reduce the length of stay for inpatient cases in healthcare centres.
- Increase the skill-mix of staff to ensure prisoners have access to the appropriate range of services to NHS standards;
- Facilitate and encourage information sharing among staff and reduce professional isolation;
- Ensure quick and effective transfer arrangements for prisoners requiring transfer to and from appropriate NHS facilities;
- Provide therapeutic activity for patients to improve health and social functioning.

Additionally, the NFS highlight that continuity of care is essential and health and local authorities should be involved in assessing the mental health needs of prisoners during their time in custody and in preparation for their release, contributing to their through-care and release plans for support in the community. [108]

The prison service order 2700 outlines the responsibilities of healthcare and prison staff towards prisoners identified as at-risk of suicide or self-harm in terms of: the early period in custody; required actions following and incident of self-harm; managing prisoners identified as at-risk to self; and the role of the Samaritans and peer-group support. It highlights the requirement for the production of a local suicide and self-harm prevention strategy.

6.4 Substance and alcohol misuse

6.4.1 Substance misuse

The PSO for clinical services for substance misusers outlined standards for prisons in regards to effective clinical management of substance misusers to be delivered by evidence-based services in 2000.[109] This guidance has subsequently been superseded the two 2007 NICE guidelines on opiate detoxification and psychosocial management of drug misusers in the community and prison settings.

Both NICE guidelines state that prisoners should have access to the same options for treatment as people in the community. For detoxification services these include: prior stabilisation of opioid use through pharmacological treatment; effective coordination of care by specialist or competent primary practitioners; the provision of psychosocial interventions, where appropriate.[110] Additional considerations for opiate detoxification in the prison environment include:

- Practical difficulties in assessing dependence and the associated risk of opioid toxicity early in treatment
- Length of sentence or remand period, and the possibility of unplanned release
- Risks of self-harm, death or post-release overdose.

Psychosocial management treatment options should include: contingency management, therapy and cognitive behavioural therapy and should encourage and facilitate participation in self-help groups.[111] Additional considerations specific to the prison setting include:

- The length of sentence or remand period, and the possibility of unplanned release
- Risks of self-harm, death or post-release overdose.

Following successful opioid detoxification all service users should be offered continued treatment, support and monitoring designed to maintain abstinence. This should normally be for a period of at least 6 months.

Partnership working with Counselling, Assessment, Referral, Advice and Throughcare drug workers and local specialist drug misuse services will ensure a coordinated service is delivered across the different care sectors and effective throughcare is provided for prisoners.

6.4.2 Alcohol misuse

Alcohol use and misuse are major contributory factor in crime: 63% of sentenced males are classed as hazardous drinkers; 53% of those with a main offence of violence had taken alcohol; 9% of those assessed by CARAT services said alcohol was their main problem drug; 28% of those with a main offence of violence said alcohol was their main problem drug; home office statistics show that one fifth of the prison population are violent offenders; and those prisoners identified as having a hazardous drinking problem are also more likely to experience a whole range of other problems such as mental illness, drug use and homelessness.[112,113]

The Department of Health's guideline on the clinical management of drug dependence in the adult prison setting outlines the processes to achieve safe and effective alcohol services within prison

- Reception screening: identify alcohol use and dependence levels, determine immediate healthcare needs including withdrawal;
- Treatment: closely tailored to an individual's needs and motivation. A comprehensive treatment framework includes:
  (i) Detoxification –should be undertaken in healthcare with the support of a healthcare professional.
  (ii) Structured counselling – including motivational therapy, coping/social skills training, behavioural self-control training, marital/family therapy.
  (iii) Specialised residential services – for those needing more intensive interventions
  (iv) Self-help groups – such as Alcoholics Anonymous[114]

6.5 Outpatient escorts and bed-watches

'Escorts' describes the process of prison staff escorting prisoners to and from outpatient appointments, and closely supervising them for the duration of such appointments, to ensure that they behave and do not escape. 'Bed-watches' are the constant supervision by prison staff. Both are a highly significant areas of healthcare activity in most prisons and place considerable operational pressures on the workload of both healthcare and prison staff.[115]

The clinical governance of this area is particularly important to maintain an appropriate balance between the demands of patient care and custody.[116] Therefore:

- Prison Health Partnership Boards should ensure that the management of outpatient escorts and NHS inpatient bed-watches form part of local clinical governance procedures and that these are reviewed at least annually.
- Audit local patterns of OPD referral and A&E attendance, including clinical referral patterns and cancellations.
- Referral patterns should be regularly discussed at establishments' local forums for clinical effectiveness.

The additional operational pressure of the escort in terms of staffing, security and cost, is not present in normal NHS referral. Alternative service models may also be appropriate where patient numbers, security risk and availability of clinical facilities indicate. Such models might include:

- Members of specialist teams visiting the prison and the establishment of formal Service Level Agreements with providers allowing input from a wider specialist team.
- Arranging with local trusts that hospital and A&E waiting times take place in the prison allowing prompt access on arrival.
- Telemedicine

6.6 Allied health care

The principle of "equivalence of care" in prison medicine is a principle by which prison health services are obliged to provide prisoners with care of a quality equivalent to that provided for the general public in the same country. This includes access to allied healthcare services such as physiotherapy, occupational therapy, dietetics, and speech and language therapy. The healthcare standards for prisons recognise the importance of access to these services for those with mental ill health.[117] However, integrated multidisciplinary team care based around the different needs of prisoners should be provided for the whole prison population.

6.7 Health promotion and education

Prison can provide a key role in providing people with healthcare that they might not otherwise receive in the wider community and the Government's programme for tackling health inequalities recognises that prison is an important setting for health promotion activities.[118] The 'Health Promoting Prison' approach has developed the idea of a whole prison approach to improving health within the prison environment. This approach aims to:

- Build the physical, mental and social health of prisoners as part of a whole prison approach.
- Help prevent the deterioration of prisoners' health during or because of custody, especially by building on the concept of decency in our prisons.
- Help prisoners adopt healthy behaviours that can be taken back into the community upon release.[119]

The health promotion PSO stated that prisons must ensure that health promotion considerations are adequately and explicitly included within the local planning mechanisms, which are drawn up in partnership with their PCT, and must include as a minimum the following areas

- Mental health promotion and well being
- Smoking
- Healthy eating and nutrition
- Healthy lifestyles, including sex and relationships and active living
- Substance and alcohol misuse

Some health promotion work has already been undertaken with prisoners. Results from prison smoking cessation programmes continue to be encouraging, with quit rates as good as, or better than, those in the outside community.[120]

The model for service delivery outlines the core principles for the 'whole prison approach' to health promoting prisons

- Promoting health in Prisons is core work for both the NHS and Prison Service;
- In line with the principles of the NHS Plan, prisons will provide services and support to individuals in relation to health promotion, disease prevention, self care, rehabilitation and after care;
- Improving the health and well-being of prisoners is recognised as a vital element in their rehabilitation and resettlement;
- The needs and preferences of the target group in prisons will shape health promotion policy and practice;
- As well as providing health education and other forms of health promotion, the Prison Service will work with others to address social, environmental and

economic factors that impact on health in order to tackle health inequalities more broadly; and

- The prison regime and environment should be assessed with regard to the concept of decency.

6. Conclusion and recommendations

Prisoners should receive the same level of community care within prison as they would receive in the wider community.[121] A truly integrated health care system would extend services to all agencies responsible for issues contributing to the health of the population, from health agencies to non-health agencies across government, to non-government organisations, to informal community networks, and beyond.[122] The recommendations outlined below recognise the challenges of providing a truly equivalent healthcare system within the prison environment. However, prison healthcare services have a central role in improving the health of some of the most difficult to reach groups within the local community.

Today's prisons are not completely closed systems, they have transient populations and where the health needs of individuals not addressed within the prison environment are exported back to the wider community upon release.[123] HMP Lewes is no exception to this with most individuals who spend time within the prison returning to the local community. Services provided within the prison environment could improve nutrition; reduce consumption of tobacco, drugs, and alcohol; and provide remedial education programmes and job training, so improving the health of prisoners. Therefore, the period of imprisonment could be viewed as an opportunity to improve the health of prisoners and minimise the risk of poorer health to the community.

The results of this needs assessment show that there is a continued need for further investment in the healthcare services provided at HMP Lewes. The level of need within the population will continue to increase with the expansion of the population and in order to meet this, the PCT, in partnership with HMP Lewes management, must ensure that services are appropriately designed and supported.

Area	Gap	Recommendation
Service management and commissioning		
		A dedicated prison commissioner is required to clarify commissioning arrangements. Priority areas include: contract for GP services; contract for forensic psychiatric service; and formalised arrangements with allied health services. Development of the healthcare management team within the prison. Current management arrangements are unsustainable and a full review of management requirements is needed to determine the appropriate structure of the healthcare management team within the prison, including IT and administrative support.
Staff development and training		
		A formal annual review cycle for all healthcare staff including personal development plans which identify training and development needs. Clinical supervision, provided by appropriately qualified professionals, is available to all nursing staff. Development of training opportunities for healthcare staff, including training and placements outside of the prison. Full access to PCT and HMP Lewes induction for healthcare staff. Mental health awareness training available to all staff including MHP Lewes prison officers. Sexual health awareness training made available to all healthcare and prison staff.
Service user involvement		
		Formalise arrangements for user involvement in service planning. Ensure prioritised suggestions made at prisoner forum are acted on and results reported back to prisoners involved and to prison population as a whole.

Area	Gap	Recommendation
Reception screening, induction and health assessment		
	The induction process currently provides written information on healthcare services.	A formal health induction presentation, outlining services available and procedures for accessing healthcare services should be considered.
Primary care		
	The availability of modern reliable information and IT systems is required for the provision of good primary care.	The introduction of electronic medical records system will require sufficient training and support for staff is in place.
	Primary care is key to developing care for chronic and long-term conditions where clinical intervention can offer some control of the condition but not cure. *Developing and Modernising Primary Care in Prisons* states that the standards of care provided should be equivalent to those for the general population with reference to: NSFs for diabetes, coronary heart disease & long term conditions, NICE guidelines and the QOF.	Ensure primary care is modelled on the new GMS contract with the same quality and outcome framework for chronic disease, including depression and mental ill health.
		Further development of liaison with general practice, specialist health services, community and mental health services, and support agencies to ensure continuity of care for prisoners upon release or transfer.
Older prisoners		
	Currently there is no clinical lead or specific older prisoner policy for older prisoners.	The toolkit for good practice for older prisoner services should be adopted and standards met.
Communicable disease		
	The regular movement of prisoners between prisons limits access to ongoing specialist medical review and treatment for HCV	All prisoners screened positive for HCV referred to specialist services.
		To comply with *Choosing Health* priorities for improving access to healthcare for prisoner's prison services must ensure there are robust systems for the provision of continued care for prisoners following release or transfer.

Area	Gap	Recommendation
Sexual health		
		Sexual health services have recently transferred to ESDW, an assessment of service outcomes including screening, treatment and education is required to ensure all aspects of sexual health are addressed. Sexual health awareness training for staff.
Dentistry		
	The 2003 good practice guide for reforming prison dental services identifies the need for treatment based on patient need, prevention focused services and NHS equitable service provision. In order to assess what resources are required to meet dental needs, with a view to promoting the commissioning of cost-effective services prisons are expected to have a robust, costed dental action plan to direct this modernisation.	In order to establish the true level of need for dental services and to ensure services are cost effective a research study into oral health need, or oral health needs assessment, for HMP Lewes should be considered.
Pharmacy		
	Prison pharmacy services should be working towards the standards set in *'A Pharmacy Service for Prisoners'*. Specifically for HMP Lewes the service should be working towards: A more patient-focused pharmacy service, based on identified patient needs; A pharmacy service that is more accessible to the patient, and which enables direct contact between patients and pharmacy staff; A pharmacy service which supports self-care and patient self-management; Integration of pharmacy services into the overall delivery of health care services e.g. pharmacists running minor ailment and general medication advice clinics.	Further development of pharmacy capacity to ensure the standards of the *'A Pharmacy Service for Prisoners'* framework are met.
Mental health		
	Mental health represents a significant burden of	Review structure of mental health service (both

Area	Gap	Recommendation
	disease within the prison. Achieving equality of care for mental health services within prisons with community services will require massive investment in a 'stepped care' model of services, from good quality primary care for prisoners with depression and anxiety to more specialised services for those developing more severe problems.	inpatient and in-reach) to increase primary mental health and therapeutic opportunities for prisoners.
	Additionally, the NFS highlight that continuity of care is essential.	Local authorities should be involved alongside health services, in assessing the mental health needs of prisoners in preparation for their release, contributing to their through-care and release plans for support in the community.
Substance and alcohol misuse		
	The introduction of the IDTS programme during 2008-09 will ensure substance misuse services at HMP Lewes are of a 'gold standard'.	Support IDTS implementation process requirements, including support for specific substance misuse needs assessment as required as part of implementation process.
Outpatient escorts and bed-watches		
	Cancelled external appointments have been highlighted as an issue for prisoners and healthcare staff.	An audit of patterns of referral and A&E attendance, including clinical referral patterns and cancellations should be carried out on a regular basis. Finding should be discussed at establishments' local forums for clinical effectiveness. Arrangements for escorts to be better co-ordinated between healthcare and HMP Lewes management to ensure prisoners do not miss external healthcare appointments. Where cancellation is unavoidable, or a result of transfer appointments are immediately rebooked. Alternatives such as members of specialist teams visiting the prison and the establishment of formal

Area	Gap	Recommendation
		Service Level Agreements with service providers should be considered.
Health promotion and education		
	Health promotion activities should be adequately and explicitly included within the local planning mechanisms, which are drawn up in partnership with their PCT. A 'whole prison approach' to health promotion, including consideration of the broader determinants of health is required.	A health improvement development programme is required to extend and improve health promotion activities within HMP Lewes. Joint working between the ESDW PCT health improvement team, prison healthcare and the prison education and training department is required to identify key health promotion activities and programmes for HMP Lewes. Including exploring the opportunities for alternative provision of health promotion material, such as telemedicine. Increased smoking cessation training to meet current demand levels and reduce waiting times.
Allied health care		
	Prison health services are obliged to provide prisoners with care of a quality equivalent to that provided for the general public	Formalised arrangements with allied healthcare providers should include sessions held within the prison in order to avoid unnecessary outpatient appointments. A specific evaluation of the level of need for such services is required in order to clarify the level of support required.

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Appendix 1: Progress on recommendations from 2000 and 2004 HMP Lewes healthcare needs assessments

Area	2000 recommendations	2004 recommendations	2007 Progress
Physical health			
CDM	Set up chronic disease register	Nurse led clinics, particularly in chronic disease management Activate use of chronic disease registers to assist with identification and management of prisoners with chronic disease. Ensure primary care is modelled on the GMS contract, with the same indicators and quality outcome framework for chronic disease management	CDM lead nurse in place since January 2008. Introduction of the SystemOne IT system will allow better recording of chronic disease and the introduction of Quality and Outcome Framework-like performance indicators.
Immunisation		Hepatitis vaccination strategy: in liaison with GUM and substance misuse services. Ensure prisoners are offered information and advice about Hepatitis C Review policy of offering other immunisation at reception screening (MMR for young men 17-21)	
Infection control		Ensure prison healthcare staff are offered regular infection control training, for example in recognising symptoms of TB Set up monitoring and audit schedule of infection control practices with local HPU	Immunisation services within the prison are provided by the local Health Protection Unit who also provide some staff training.
Pharmacy		Development of prison formulary and establishment of Drug and Therapeutics Committee Develop leadership role for pharmacist Write and 'In Possession' policy Review of prescribing policy on in-patient wing Review of repeat prescribing and dispensing systems for the in-patient wing Review completeness of prescribing information and entry on to Pharmacy Manager system.	
Dentistry		Consider research study into oral health need in the prison.	Ongoing recommendation

Area	2000 recommendations	2004 recommendations	2007 Progress
GUM	Provide GUM services	Clear recording	From April 2008 GUM services transferred from the Claude Nicol clinic (BSUH) to East Sussex Downs and Weald PCT.
Information recording	Review of recording information	Improve identification of prisoners with disabilities at reception screening, including those with learning disabilities.	The introduction of the SystemOne IT system should allow for electronic patients records to replace paper-based records. Further investment in training and administration time to transfer data will be required.
		Upgrade information technology	
		Clearer recording of learning disability in prison inmate medical notes and any specific care plans of individuals.	
		Ensure reception screening is capturing vaccination status of prisoners and offering boosters where appropriate.	
		Review recording of information on healthcare information system for completeness	
	Co-ordinate health services	Shared information with GPs and other healthcare workers in the community	Further development of liaison with community general practice and other prison health services is required to ensure continuity of care for prisoners upon release or transfer.
		Prison health record at discharge from prison	
Inmate information	Improve information to inmates	Provide written information on how to access prison healthcare services to prisoners	Information leaflets are available at reception. Further development of induction programme to provide information on healthcare services within the prison and how to access is requirerd.
		Provide health information leaflets in library (including leaflets in languages other than English)	
		Provide patient information on oral health in both written and visual format.	
Mental health			
	Implement a suicide prevention strategy	Make provision for treatment of depression and anxiety, including counselling	Further development of the prison mental health in-reach team alongside reconfiguration of all mental health services is planned for 2008.
	Develop the care pathway between CARATs and outside agencies	Development of in-reach team working protocols, with specific information on the management of dual diagnosis prisoners.	
		Build programme of joint working with diversity manager, particularly around promoting mental health	
		Mental health promotion integrated into induction programme.	

Area	2000 recommendations	2004 recommendations	2007 Progress
Substance misuse	Introduce and co-ordinate a drug detoxification programme	Liaising with substance misuse team in order to develop working protocols and pathways of care.	The introduction of IDTS during 2008 will continue to improve substance misuse treatment within the prison. The programme will be fully operative in April 2009.
		Link alcohol detoxification to local alcohol strategy	Further work on alcohol will be introduced with IDTS.
Health promotion			
	Improve links with health promotion	Build joint working with lifelong skills manager for broader health promotion initiatives including teenage parenting and family skills	A health improvement development programme is required to extend and improve health promotion activities within HMP Lewes.
		Ensure mental health promotion is part of health promotion strategy.	
		Annual timetable of health promotion events for both staff and prisoners.	
		Health promotion to participate in induction	Joint working between the PCT health improvement team, prison healthcare and the prison education and training department is required to identify key health promotion activities and programmes for HMP Lewes.
		Healthy eating scheme	
		Introduction of expert patient programme.	
		Smoking cessation services continued and extended to F-block	Smoking cessation available to all prisoners. However, further training of staff to meet current demand levels and reduce waiting times is required.
Workforce			
	Rotation of staff in and out of prison	Extend prescribing to nurses in common with community practice	Nurse prescribing being introduced currently.
		Training opportunities for prison healthcare staff including training and placement outside of the prison.	Continue programme of CPD for all staff.
		Increased staffing to match workload requirements	Recruitment to vacant posts and bids for additional funding underway.
Staff health		Address concern re need for vaccination – introduction of Hepatitis B vaccine programme	
		Continue to offer smoking cessation services to staff	
		Alcohol management sessions	

Area	2000 recommendations	2004 recommendations	2007 Progress
		Review of staff access to occupational health services	
Other			
	Relationship between PCT and prison to be developed	Further engagement with the NHS by prison staff other than the Health Governor	There is a continued need for further investment in commissioning and management support into the prison from the PCT. A dedicated prison commissioner is required to clarify commissioning arrangements. A healthcare management team within the prison needs to be developed with support from and access to PCT management.
	Provide improved healthcare facilities		Healthcare wing was refurbished in 2007.
	Improve literacy		A reducing re-offending needs assessment completed in 2008 has help identify education and training requirements of prisoners.
	Improve sanitary condition in youth offending wing		YOI status was withdrawn in 200

Appendix 2: Results from prisoner health forum

	Area of Change	Prisoner score	Management score
1.	Continue existing prescriptions on arrival.	**10**	**5**
2.	Doctor's prescription in police station valid in jail.	**7**	**5**
3.	Solicitor in police station to establish medical needs.	**7**	**3**
4.	Make more effort to match existing prescription on arrival.	**9**	**6**
5.	Medication available on day of prescription.	**10**	**10**
6.	Duplicate of 2.		
7.	Provide prescribing nurse on reception.	**10**	**6**
8.	Resident GP	**5**	**5**
9.	Officers respond to Listener's ACCT recommendations.	**8**	**10**
10.	Ill patients in Segregation moved to healthcare	**8**	**8**
11.	Listener's enabled to fulfil follow-up meeting commitments.	**6**	**6**
12.	No operations cancelled through lack of prison staff	**10**	**8**
13	Medication prescribed during hospital appointments/stays retained on return to jail.	**10**	**10**
14.	Provide written confirmation of hospital appointments.	**10**	**8**
15.	Cancel 4 month post arrival wait condition for optician appointments	**6**	**8**
16.	Immediate re-booking of appointments cancelled for new arrivals.	**10**	**10**
17.	Reinstate old exercise area	**10**	**8**
18.	Increase gym sessions	**10**	**3**
19.	Reduce waiting time for smoking cessation course.	**8**	**5**
20.	Permit new arrivals to continue on smoking cessation replacement therapies	**8**	**8**

Scores >15 highlighted as those which are high priority for Prisoners and as high priority/achievable and realistic by management.

Appendix 3: Prison staff health survey 2008

All staff working at HMP Lewes (HMP prison, healthcare, and other organisations represented in the prison) were asked to fill in a health questionnaire during March 2008. The questionnaire was a modified version of "Health Counts", a survey carried out in East Sussex, Brighton & Hove during 2003. The same survey was carried out with prison staff at HMP Lewes in 2004 as part of the HCNA at that time. The results of the staff survey are compared to the 2004 findings

A3.1 Findings

400 members of staff were sent a questionnaire with their payslip at the end of February 2008. Disappointingly only 84 questionnaires were returned giving a response rate of 21% this was significantly lower than the 49% response rate achieved in 2004.

Of the respondents 63% (53) were male and 37% (27) female, three respondents did not indicate their gender. Compared to the total prison workforce, men were slightly under represented as respondents to the survey (73% of total workforce is male).

The average age of respondents was 48 years, with a range from 23 to 67 years. The respondents in 2004 were younger at an average of 45 years (18-64). The majority of respondents were white British and Irish (90.2%) or white other (3.7%) with only 2.4% identifying themselves as from black and minority ethnic (BME) groups. This reflects the local population ethnicity profile, but differs from the 2004 survey when white respondents made up a smaller proportion (88%). The proportion of respondent not answering this question was lower than in 2004 (3.7% v 6.9%). Table 1 compares the proportions of staff from different occupational groups who responded to the 2004 and 2008 surveys.

Table 1: Numbers and proportions of staff responding to health survey, by job group, 2004 and 2008

Type of job	2004		2008	
	Number of respondents	%	Number of respondents	%
Prison officers	68	44	36	43
Governors	8	5	10	12
Nursing/healthcare	15	10	4	1.4
Treasury grade	10	7.5	11	13.3
Works department/kitchens	13	8	4	4.8
Education and workshops	8	5	9	10.8
Office/admin	21	13	9	10.8
Missing	10	7.5		
Total	154	100	83	100

Compared to 2004 there was a higher representation from treasury grade and education and training staff and from governors. However, there was lower representation from healthcare and the works department.

A3.1.2 General health

Ninety percent of respondents considered their health to be 'good', 'very good' or excellent', with only 1.2% identifying their current health as 'poor'. Almost 70% of respondents considered their health the same as compared to one year age. Twenty three percent (19) of respondents identified themselves as having a long-term disability.

A3.1.3 Use of health services

Primary Care

Over three quarters (77%) had visited their GP in the past 12 months. Of those who had visited their GP 23% had been to discuss a long-term illness or disability, similar to the

22% in 2004. This reflected the proportion of respondents who identified themselves as having a long-term illness or disability (22%), this is lower than the East Sussex proportion of 28% but reflects the findings of the 2004 survey (23%)

Dentistry
Of the 78% of respondents who were registered with a dentist 54% were registered with a NHS dentist and 23% as a private dental patient. The level of registration, both NHS and private, was lower than in 2004 and the proportion of respondents not registered with a dentist has risen from 16% in 2004 to 19% in 2008. This is significantly higher than the 12% of the general population who are not registered.

Over half of the respondents (53%) had visited the dentist in the six months prior to answering the survey. However, 15% had not visited a dentist for more than two years. The most frequently cited reason for not attending the dentist was an inability to find an NHS dentist, followed by considering that they don't need to go as their teeth are OK. In 2004 the major reason for not visiting the dentist was general anxiety.

Optician and Pharmacy
Over ninety percent (93%) of respondents had visited the optician for eye-testing at least once in their life, similar to the 91% in 2004. A slightly smaller proportion of the respondents (72%) identified that they wore contact lenses or glasses compared to 2004 (76%).

In the 4 months prior to the survey 11% of respondents had sought advice from a pharmacist, with 44% indicating they take regular medicines. This level is significantly higher than the 34% in the 2004 survey, but still falls well below the general population rate of 51%.

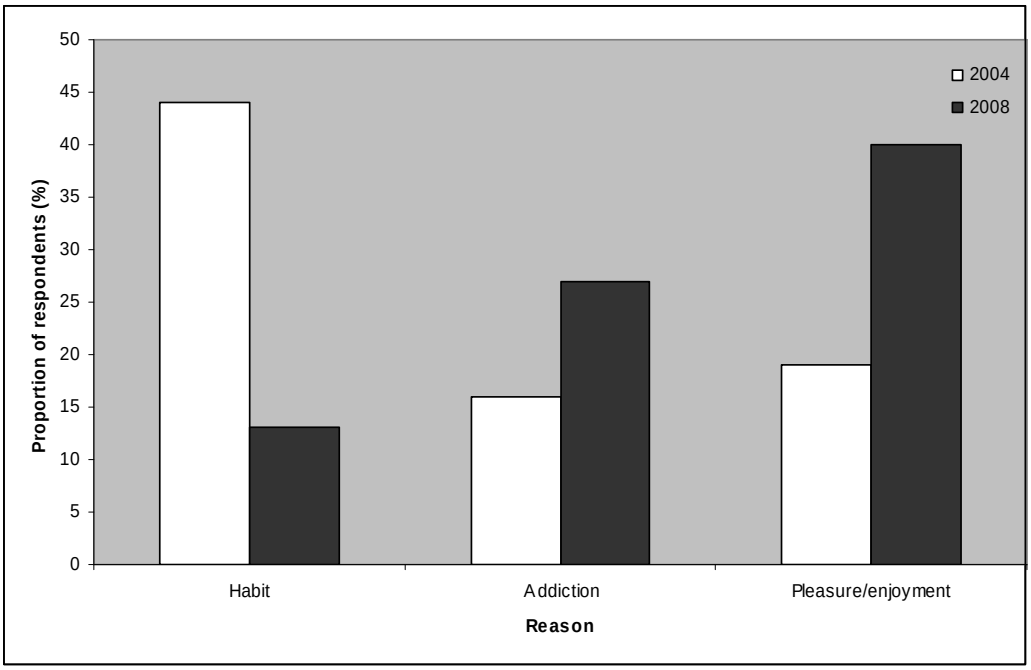
Hospital services
In the three months prior to the survey 4% of respondents had visited an accident and emergency department, slightly less than the 7% in 2004. The proportion of respondents visiting outpatients was 23% similar to the 2004 level (22%). The proportion of respondents who had been admitted as an inpatient remained constant at 7%, and there was a small increase in the proportion reporting attendance as a day case (14% v 12%).

Use of complementary services
As in 2004 the most frequently used complimentary service was osteopaths. The use of complimentary services by prison staff remains low with 78% of respondents indicating they had not seen any complimentary therapists.

A3.1.3 Health-related behaviour

Smoking
The proportion of daily smokers (16%) was significantly lower than in 2004 (23%) as had the proportion of occasional smokers (2% v 5%). Figure 1 compares the main reasons identified for smoking.

Figure 1: reasons for smoking, 2004 v 2008



A smaller proportion of staff indicated that the want to give up smoking (62%) compared to 2004 (72%). However a similar proportion had attempted to give up (40% v 48%). A larger proportion was aware of the availability of smoking cessation services (80%) than in 2004 (73%), with 25% having tried to use them higher than the 19% in 2004.

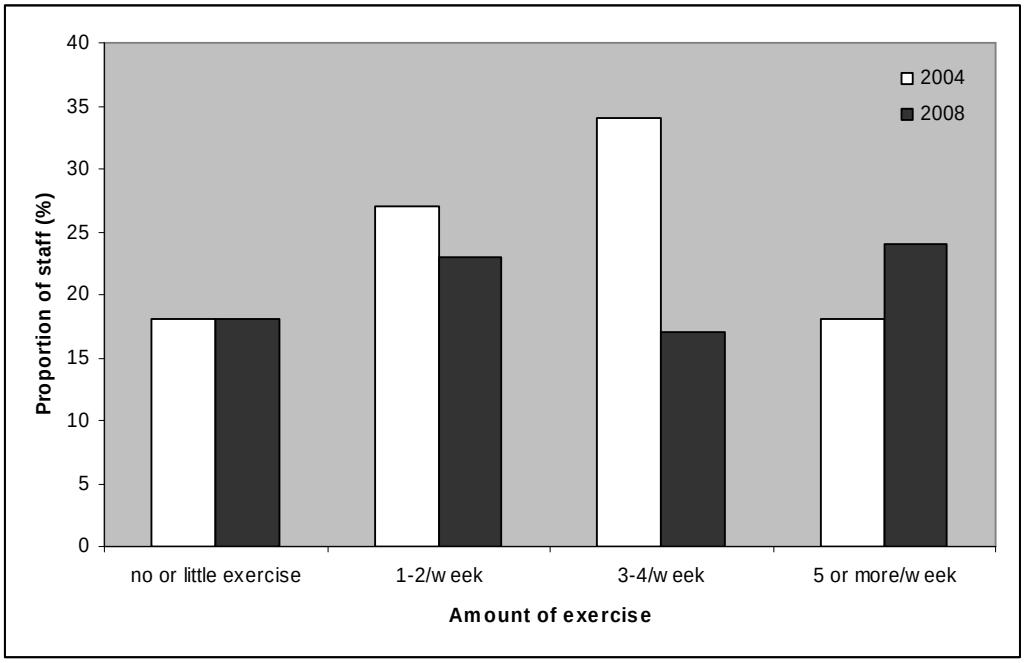
Alcohol

Only 11% of respondents identified that they drink daily, less than proportion in 2004 (17%). An additional 7% drink 5-6 days a week and 23% drink 3-4 days a week; in 2004 the proportions were 14% and 15% respectively indicating that the amount of alcohol consumption has decreased. The proportion of respondents who had attempted to cut their drinking has also decreased from 19% in 2004 to 16% in 2008.

Exercise and food

The proportion of staff undertaking little or no exercise has remained constant at 18% since 2004. A decrease in the proportion of staff exercising once to four times a week is offset by an increase in the proportion reporting undertaking five or more sessions of exercise (Figure 2).

Figure 2: Level of exercise, 2004 v 2008



Over 50% of respondents indicated that they ate five or more portions of fruit and vegetables on a daily basis, up from 24% in 2004. Only one percent of staff considers that they are underweight, with 37% considering themselves the right weight, 49% considering themselves overweight, 10% very overweight and 1% unsure. These reflect calculated BMI patterns and the patters reported in 2004.

A3.2 Summary

The poor response rate to the 2008 survey makes comparison to the 2004 survey difficult. However, results do suggest that use of health services by prison staff has remained similar for most areas except dentistry. Perceived difficulties in accessing NHS dentists has increased since the introduction of the new dental contract (2006/7) and is the major source of complaints from the general public to the local PCT.

The apparent improvement in health-related behaviours included reduced proportion of smokers and daily drinkers and increased proportion of those exercising at or above recommended levels and consuming the recommended five portions of fruit and vegetables daily may be a result of responder bias. However, in the four years between the two surveys a number of significant awareness raising campaigns for these issues have been carried out and national ban on smoking in public places was introduced in 2007, which may also account for the changes.

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